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ABSTRACT

The Elder Abuse Prevention Project sponsored by the Seniors' Education Centre, University Extension, University of Regina (Saskatchewan, Canada) emerged from a provincial workshop held by the Centre in 1989. The workshop was designed to examine possible avenues for addressing elder abuse issues in Saskatchewan. The purposes of the project were to increase sensitivity and awareness of elder abuse issues and resources; help create resource networks; develop partnerships between seniors and professionals; and help foster local helping networks for intervention and prevention. This document presents an educational resource tool designed for use by both seniors and professionals in Saskatchewan and other provinces and territories. The module is meant to encourage and assist individuals to further develop their knowledge and skills as well as continue educational activities regarding elder abuse. The opening sections of this guide cover the general preparatory work needed to help organize, plan, design, and present an elder abuse workshop. They include information on organizing a workshop, adult learning guidelines, designing a workshop, and outlines for full-day, half-day and one-hour workshops. By far the greater part of the guide consists of eight appendixes which provide: all of the background reading for the workshop itself; abbreviated facilitator notes on each topic; group activity suggestions; overheads and handouts; a sample evaluation for readers to photocopy and use with workshop participants. summaries of two reading resources; a glossary; and a bibliography listing resources for materials and 36 texts and articles. (NB)

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Elder Abuse Awareness Module

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FRONT COVER

The front cover graphic symbolizes a holistic healing process (the sun) which involves venturing forth to explore new horizons (the horizon), and daring to take flight to find innovative and progressive ways in which to prevent elder abuse (the bird). Healing begins with awareness of ourselves and the issues, followed by a commitment to take action. The front cover graphic symbolizes what the Elder Abuse Prevention Project has been trying to achieve and what we hope this module will help to facilitate.

SENIORS' EDUCATION CENTRE
UNIVERSITY OF REGINA EXTENSION
ELDER ABUSE PREVENTION PROJECT
ELDER ABUSE AWARENESS MODULE

EVALUATION SHEET FOR USERS OF THE MODULE

The Seniors' Education Centre is interested in knowing how you feel about this module and how effective it was (or will be) for your workshop purposes.

Please answer the following questions and send this form to:

SENIORS' EDUCATION CENTRE
ELDER ABUSE AWARENESS PROJECT
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1. Please list 2 or 3 items you like about this module.

2. Please list 2 or 3 items which you do not like about this module.

3. Do you have any further comments or suggestions for this module which you feel would help in future projects on elder abuse within the Seniors' Education Centre?

Thank you for your cooperation.

ELDER ABUSE AWARENESS MODULE

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This document was made possible with assistance from the following: the Family Violence Prevention Division, the Seniors' Independence Program, and New Horizons, Health and Welfare Canada; the Saskatchewan Seniors' Secretariat; the Saskatchewan Family Foundation; and the Seniors' University Group Incorporated.

October 1992

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MODULE DEVELOPERS

Material in this Module is a result of cooperative effort. The content on elder abuse was developed by Patricia MacKenzie and Elliot Paus Jenssen. The sections on workshop preparation, design and editing were completed by Carol Stevenson Seller. Overall production and printing were arranged for the Senior Education Centre by Darla Goettler, Project Coordinator, Elder Abuse Prevention Project.

Patricia MacKenzie is assistant professor of Social Work, University of Regina. She chairs the social policy and practice committee of the Canadian Association on Gerontology, is president of the Saskatchewan Association of Social Workers, and authored chapters in four text books on social work with aging populations.

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INTRODUCTION TO THE ELDER ABUSE PREVENTION PROJECT

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ELDER ABUSE PREVENTION PROJECT

The Elder Abuse Prevention Project sponsored by the Seniors' Education Centre, University Extension, University of Regina, emerged from a provincial workshop held by the Centre in 1989. The *Focus on Elder Abuse Workshop* examined possible avenues for addressing elder abuse issues in Saskatchewan. One of the recommendations was that the Centre provide increased public education on elder abuse, on both a local and regional basis, to the general public, seniors, and professionals. In the fall of 1989, the preliminary findings of the *National Survey on Abuse of the Elderly in Canada* were released, confirming that elder abuse and neglect is a serious problem in Canada. National findings and encouragement from federal and provincial agencies, combined with expressed educational needs of Saskatchewan seniors and professionals, led the Seniors' Education Centre to develop an elder abuse educational project.

The aims of the **Elder Abuse Prevention Project** were to provide training about elder abuse and to raise awareness of seniors and professionals regarding related issues and resources, via the following phases: a public information dissemination campaign, a central Saskatchewan training forum, decentralized community workshops, and a provincial conference. Older adults and seniors' groups throughout the province, as well as professionals, were actively involved. The project was designed and supervised by John Oussoren, Centre Director; Lori Draper, Coordinator (phase one); and Darla Goettler, Coordinator (phases two to four). It has been guided by a provincial advisory group of older adults and professionals from social work, health care, clergy, mental health, family violence, and law enforcement agencies, and with representation from the aboriginal community.

The goals of the Elder Abuse Prevention Project have been to: 1) increase sensitivity and awareness of elder abuse issues and resources; 2) help create resource networks; 3) develop partnerships between seniors and professionals; and 4) help foster local helping networks for intervention and prevention. The project has aimed to meet these goals throughout the province of Saskatchewan, by means of the multi-phased approach described above.

Phase One, funded by New Horizons, Health and Welfare Canada, and supported by the Seniors' University Group, Inc., enabled the Elder Abuse Prevention Project to develop, test and distribute two informational pamphlets as well as create an inventory of informational resources on elder abuse. An **Elder**

Abuse Literature Summary was also produced and is available from the Seniors' Education Centre.

Phase Two was a **Central Training Forum** designed to train teams of seniors and professionals from targeted areas on the issue of elder abuse and the presentation of material to people in their local communities. The two-day forum was held in January 1992 in Regina. Participants learned skills to become future trainers at community workshops on elder abuse issues and resources. This phase was funded by the Family Violence Prevention Division of Health and Welfare Canada and by the Saskatchewan Seniors' Secretariat and Family Foundation.

Phase Three consisted of a series of **Decentralized Workshops** led by trained teams of seniors and professionals from seven communities in Saskatchewan. The local workshops were designed to provide elder abuse training to seniors and professionals in their own communities. The communities in which workshops were held during the spring of 1992 were as follows:

Regina
Prince Albert
La Ronge
Yorkton
Saskatoon
North Battleford
Swift Current

This phase was funded by the Seniors Independence Program, Health and Welfare Canada, the Saskatchewan Seniors' Secretariat and the Saskatchewan Family Foundation.

Phase Four involved the hosting of a **Provincial Conference** on elder abuse to further the training of the teams of seniors and professionals involved in elder abuse prevention, and to encourage other interested seniors and professionals to become aware of elder abuse issues, resources, and networks. The October 1992 provincial conference gave seniors and professionals an opportunity to evaluate the impact of, and the processes involved in, phases one to three, as well as to make recommendations regarding further responses to the issue of elder abuse in Saskatchewan.

The success of the Elder Abuse Prevention Project has been due to a number of skilled and dedicated individuals.

Phase one activities were coordinated by Lori Draper with much encouragement and assistance from the Seniors' University Group.

Darla Goettler coordinated phases two to four with the assistance of seniors and professionals throughout the province. The twelve Project Advisory Group members were: Brenda Green, LaRonge; Opal Stieb, Canwood; Doreen Cheetham, North Battleford; Delores Dzubin, Saskatoon; Steve Ripplinger, Davidson; Doreen Ryan, Yorkton; Gerry Hollman, Yorkton; ElseMarie DePauw, Swift Current; Arvey Hanowski; Lucy Eley; Cathy Dermody; and Rod McKendrick, all of Regina.

Thirty-five community volunteers were instructed as elder abuse prevention trainers in phase two, and they in turn organized and implemented local workshops during phase three. It was these community-based individuals who were instrumental in raising awareness and concern of elder abuse issues on a province-wide basis.

Several individuals lent support throughout the entire project: John Oussoren, Seniors' Education Centre; Brenda Righetti, Saskatchewan Seniors' Secretariat; Larry Flynn, Seniors Independence Program; Norma Wallace, New Horizons; and Kataline Kennedy, Family Violence Prevention Division. Their expertise and dedication assisted in pioneering in the field of elder abuse within Saskatchewan.

The Elder Abuse Prevention Project, which was based on a **Partnership Model** of education, was successful in bringing together seniors and professionals to form integrated training teams, increasing networking around elder abuse issues and resources, and effectively involving seniors in the planning and delivery of the project. The project was also successful in developing a multi-disciplinary and generic training module for use in the elder abuse prevention field.

The **Elder Abuse Awareness Module**, which follows, is an educational resource tool useful for both seniors and professionals in Saskatchewan and other provinces or territories. The module is meant to encourage and assist individuals to further develop their knowledge and skills as well as continue educational activities regarding elder abuse.

Darla Goettler, Project Coordinator
Elder Abuse Prevention Project
October, 1992

HOW TO USE THIS GUIDE

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HOW TO USE THIS GUIDE

This information binder is intended to assist and help simplify your workshop organizing, planning, design and presentation.

Part one covers the general preparatory work and includes three options for workshop outlines.

Part two (appendices) includes all of the background reading for the workshop itself; abbreviated facilitator notes on each topic; group activity suggestions; overheads; handouts; and a sample evaluation for you to photocopy and use with participants.

Sections are divided by indexes to help you find them more easily. Note also, the relationship between WORKSHOP CONTENT AND FACILITATOR NOTES: Workshop content is the background reading on each topic. Facilitator Notes cover the identical topics, but are abbreviated for you to use as your notes for conducting the workshop. You will have to pick and choose which of these topics to cover, and once you have decided that, you can then take out these sections and use them in your workshop. Similarly, you can pick items from Group Activities (video vignettes, case studies, discussion questions) that are appropriate for your situation.

What This Guidebook is Not

This guide is not intended to be the final work on elder abuse. It really is the beginning of what is hoped will be the raising of our collective consciousness about a very important issue.

The guide is written with a bias toward the dominant culture simply because this is where research is available. Research pertaining to elder abuse in other cultures such as Aboriginal and Immigrant is sparse to non-existent. In order to adapt a document like this one, considerable more consultation and research needs to be undertaken with Aboriginal and Immigrant communities. More needs to be learned about elder abuse throughout our various cultural groups and we hope that this guide will be a starting point.

It is hoped this Awareness Module will make an important beginning in raising the issue of elder abuse, where it is happening and where the key to its prevention lies - in our local communities.

ORGANIZING A WORKSHOP

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ORGANIZING A WORKSHOP

This is best done by a small group or committee with each person taking responsibility for a task.

I. *Identifying and Gathering Your Audience*

A. Identify your target group.

1. You might be aiming at the general public or at service or community groups such as: Kiwanis, Kinsmen, Rotary Club, YWCA, YMCA, Women's Institute, Lodges, Hospital Auxiliary, Legion, etc.
2. Self-help groups such as Alzheimers Support Group, Alcoholics Anonymous, etc. Telephone your community health unit to find out what support groups are meeting in your area. Be sure to find out who the contact person is in that group.
3. Churches.
4. Seniors groups.
5. Continuing adult education in your local school or regional college.
6. Local Health Unit staff.
7. Homemakers.
8. Staff of Care Facilities, including hospitals.
9. Referrals from previous audiences.
10. Professional groups and associations.

It can be helpful to include this workshop in the program of your regional community college. Given sufficient notice the local organization can be a co-sponsor and advertise in its calendar for the programming term.

B. Advertising

Once you have identified your target groups, get in touch with one of their representatives. Your identified target audience may well dictate any further advertising that needs to be done. For example, you may have arranged to speak at a Kiwanis Meeting, which is open to members only. Each organization will have its own way of letting the members know about your presentation.

Advertising that can be done to attract the attention of the general public could be:

1. Public service announcements (free) in your local newspaper, radio stations, and TV station.
2. Contact your local radio talk show host about being a guest on his/her program.
3. Contact your local cable TV station for an interview or to show a video on elder abuse.
4. Poster/notices on bulletin boards in your:
   - Library
   - Community center/hall
   - Laundromats
   - Shopping malls/stores
   - Drop-in centers
   - Doctors' Offices/Health Units
   - Recreational centers
5. Church Bulletin/Announcements.
6. Telephone campaign/word of mouth.
7. Flyers to relevant agencies. Consider style, cost, distribution.
8. Other

II. *Setting Up the Workshop*

A. Facilities

1. Find out what facilities are available for meetings in your area. Suggestions are:

* Community centers/halls
* Drop-in centers
* Community or Regional College
* School classrooms/auditoriums
* Meeting rooms in local restaurants and hotels/motels
* Libraries
* Churches
* Senior Centers

Make sure the facility is easily accessible (i.e.: wheel chairs, no stairs, etc.)

2. Information you will need to find out about each facility:

* is it within easy accessibility to your target audience?
* wheelchair accessibility
* number of people it will accommodate
* does location contain all the necessary amenities? (i.e.: a place to prepare and serve refreshments, washrooms)
* who to contact for booking
* the period of notice required for booking
* cost/rental fee
* maintenance - are you expected to clean up following the presentation?
* who will do the set up and room arrangement?
* does facility provide refreshments and audio-visual equipment and is this included in the rental fee for the facility?
* is there adequate lighting, ventilation and acoustics?
* other

B. Participants

Estimate the number of people you expect to participate in your presentation. This will determine the size of the facility you will be booking.

C. Dates/Times

When booking the facility have alternative dates and times available, in case your initial request cannot be honored.

Check your community calendar to avoid dates with conflicting activities for your target audience.

D. Equipment

Determine what you need (microphone, overhead projector, flip chart, blackboard). Is this equipment provided with the room? If not, where is it available, and what is the rental fee? Do you know how to operate the equipment? So often you will find that whatever can go wrong, will go wrong. With that in mind do you have an extra bulb for the overhead projector and do you know how to replace it? Do you pick the equipment up and return it? If so, where? Where can you plug the projector in to an outlet? Do you need an extension cord? Bring extra pencils and paper for participants.

E. Meeting Room

1) Book Meeting space
2) Room set up:

_____ round tables with _____ at each table
_____ square tables with _____ at each table
_____ individual chairs in small circles with
_____ in each circle
_____ semi-circle with chairs in rows
_____ workshop leader's table

F. Food and Beverages

Lunch:
1) catered, by whom, menu
2) bag lunch
- notice sent out by whom
- when will notice be sent out

Breaks:
1) Pre-session refreshments
- time
- who is responsible
- for how many people
- beverages
- snacks
2) Mid-morning
- time
- who is responsible
- for how many people
- beverages
- snacks
3) Mid-afternoon
- time
- who is responsible
- for how many people
- beverages
- snacks

G. Fee for Workshop

The fee you are charging the participants will depend on the cost of the workshop. Items you need to calculate into your costs are:

1. Rental of:	Check off when completed
a) facilities	________
b) audio-visual equipment	________

2. Refreshments:

a) coffee, tea, juice ________
b) cups, spoons ________
c) cream, sweeteners ________

3. Mailing:

a) stamps ________
b) envelopes ________

4. Paperwork:

a) name tags ________
b) registration forms ________
c) photocopy handouts and evaluation forms ________
d) confirmation letters ________

5. Honoraria/Speaker Fees: ________

Once you have estimated your costs, you must determine if you are going to charge the individual participants or if the sponsoring group will absorb the costs.

III. *Preparing Yourself*

A. Information Gathering

1. Read as many as possible of the books listed in the bibliography and any articles you can find at your library.

2. Ask questions of the health care professionals such as doctors, social workers, community health nurses, etc. The more informed you are, the easier it is to deliver your presentation.

B. Practice the Presentation

1. Practice the content of the presentation out loud. Speak slowly and clearly. This will help you to develop your timing as well. However, do not expect to memorize. Feel able to speak freely.

2. Practice using your overhead projector and videos.

C. Getting Ready

1. Prepare a checklist for yourself to ensure that you have not overlooked anything.

IV. *The Presentation*

1. Arrive one half hour early to make sure that everything is arranged as you planned.

2. You can assist your audience to feel at ease by:

   a) Introducing yourself: name, role, interest in topic, etc.
   b) Finding out some general background information about your participants (i.e.: what is their interest in abuse, do they work with elders, etc.)
   c) Explaining the sequence of the presentation including coffee time, time you expect to finish, etc.
   d) Explaining the process you will use in your presentation (e.g.: lecture, discussion groups, role play, etc.)
   e) Telling the participants where the washrooms are located, and any other housekeeping announcements you feel are necessary.

V. *Post Course*

1. Evaluate the feedback you received from your participants. Pat yourself on the back for your good efforts. Ask yourself, **"What can I do to improve the presentation the next time?" Did you encounter any difficulties?** If so, make a note of these items, so that you can make the necessary changes at the next presentation.

ADULT LEARNING GUIDELINES

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ADULT LEARNING GUIDELINES

FIVE THINGS WE KNOW ABOUT ADULT LEARNERS

For the most part, the people who attend these workshops will do so because of their own interest in and concern about elder abuse. In other words, they will be motivated to be there.

Your job as workshop leader is to provide a process in which people may participate in doing their own learning.

This is where knowing how adults learn best is an asset. It will help you design a better workshop. From a whole body of information about adult learners, here are five key points to consider:

1. **Adults learn best when they are treated with respect.**
   - never "talk down" to participants
   - promote inquiry into issues - get the group asking questions

2. **Adults learn through reflection on their own experience, and the experience of others.**
   - avoid lengthy one-way lectures or "talking to" the group
   - present information in short, point form lecturettes
   - use interactive methods such as discussion in pairs, trios, small groups or case studies that allow the group to actively participate

3. **Adults are capable of taking responsibility for their own learning.**
   - encourage the group to talk about what they want to know about the topic at hand (e.g.: What do you want to know about elder abuse?)
   - ask questions that help the group identify their learning (see next section on "How to Ask Questions")

4. **Adults learn what they perceive to be useful in their own life situations.**
   - provide opportunities for the group to share how this topic affects their lives
   - provide information about the social context of the topic
   - include opportunities to apply their learnings to real life situations

5. **Adults learn best in a climate that is informal and personal.**
   - provide time for participants to get acquainted and make personal connections with other participants (see notes on climate setting)

NINE WAYS TO ENCOURAGE ACTIVE GROUP PARTICIPATION

Active involvement increases learning. Consider these methods for increasing participation.

1. **Provide exercises for get-acquainted and community building:**
   - beginning exercises should call on past experience that is common to as many people as possible so people feel they have something to contribute and, therefore, have a sense of belonging (e.g.: Why is the topic of elder abuse of interest to you?)

2. **Introduce the purpose, objectives, agenda at the beginning:**
   - these need to be written on flip charts and posted, or done as a handout
   - participants need to know what they can expect or not expect from the workshop

3. **Be clear about ground rules:**
   - when are breaks and lunch? Knowing the location of the washrooms, smoking and non-smoking areas will help people feel at ease.
   - inform participants about your style of leadership (e.g.: "Please ask questions or share your ideas along the way")
   - set standards around confidentiality if this is an issue

4. **Give specific directions verbally and visually (on flipcharts or handouts) on:**
   - how to break into groups
   - what the groups are to do
   - how much time they have to do an activity
   - choosing a leader, recorder, timekeeper
   - how to report back to total group

5. **Small group discussion:**
- can be in pairs (find a partner)
- can be in threes (find two other people)
- can be in groups up to five people
- divide into small groups in any of these ways:
- number off (decide on the number of people you want in each group, and divide that number into the total number of participants (e.g.: four persons per group, 20 participants = 20 divided by 4 = 5 groups)
- color code or symbol - decide on the number of people you want in each group. Select that number of different colors or symbols (e.g.: all the reds get together, all the blues, etc. or all the oak trees get together, all the elms, the spruces, etc.)
- provide two or three guide questions to guide the group discussion. Make sure everyone can see this easily.
- have the groups choose: (1) a recorder (take notes or put on flip chart); (2) a time keeper to make sure the group keeps moving; (3) a facilitator to initiate the discussion.

6. **Recording information from group discussion on flipchart:**
- listen carefully so you record what is said and not your interpretation of what is said
- if you change wording slightly, check with the person to make sure that is what she or he means
- print large enough to be seen by all
- use dark colored markers (black, blue, dark green, dark purple, brown) for printing. Lighter colors can underline important words, or indicate each key point.
- do not crowd words on the flip chart

7. **How to ask questions that encourage participation:**
- avoid closed questions to which persons can only respond "yes" or "no", unless that is exactly what you want (e.g.: "Does anyone know what percentage of our population is 65 or over?")
- ask open-ended questions to encourage people to think, start a discussion and bring out a variety of opinions (e.g.: * What do you think are the issues in the film vignette about Margo? * In what ways might you help decrease an elderly person's isolation?)
- relay a question asked by a participant. Instead of answering each question, open the question to the group and invite response from other participants (e.g.: "That's an interesting and important question--what do the rest of you think of that?")

- if one or two people are dominating the responses to questions, you might say:
    - * "Let's hear what some others think about this."
    - * "Let's hear from someone in group "x" on this one."
- examples of open-ended questions:
    - * "Where does this information come from?"
    - * "Why do you feel this is the case?"
    - * "In what ways is this problem complex?"

8. **Always respond to participant contributions:**
    - if not acknowledged, this is very hard for a person to take and may color their ability to get the most out of the workshop
    - even if a contribution seems "off the mark", it is important to respond. In this case, you might say, "That's another whole issue which is worth pursuing, however, given our focus today, we will not cover it directly" OR "Let's hold onto that comment, note it on flip chart, then deal with it when we come to ____________."

9. **Check in with the group periodically:**
    - is the content making sense?
    - how is your energy for this part?
    - are you physically comfortable?
    - can you see? hear? etc.

DESIGNING A WORKSHOP

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DESIGNING A WORKSHOP

IDEAS FOR GETTING ACQUAINTED, COMMUNITY BUILDING, AND ENERGIZERS

Getting Acquainted and Community Building

This will vary, depending on the length of the workshop, and whether or not participants know one another and the facilitator.

1. Invite participants to say their name, where they are from (perhaps what they do, and one reason for attending the workshop; the latter will help you know their expectations for this time).

2. In addition to names, you might have the participants do one of the following:
   - identify one reason they are concerned about this topic
   - if I could do one thing to help prevent elder abuse, it would be ...
   - one thing I hope to get out of this workshop is ...
   - I am here today because ...

Energizers

When you suggest physical exercises, make sure people feel okay about doing them at their own pace and ability or that they can opt out.

1. Deep breathing (standing or seated with room to move arms)
   - On the deep breath in, slowly raise arms above head. Then exhale through the mouth in a whoosh, at the same time bending toward floor. Repeat three to four times.

2. Neck rolls (do only if you have no neck problems)
   - Tuck chin in toward chest; roll head to look over left shoulder; roll back to chest, then over to right shoulder. Repeat two to three times.

3. Stretching (standing or sitting)
   - Reach down towards floor on left side. Reach down towards floor on right side (pretend there is a $500.00 bill you are reaching for).

4. Toes and Heels Stretch (seated)
   - Stretch toes out in front as far as possible. Then stretch heels out in front of you as far as possible (good for the ham strings!). Repeat two to three times.

5. Shoulder Rolls (standing or sitting)
   - Let shoulders relax, move them forward, move them up and back, let them relax. Repeat two to three times.

6. General Stretch
   - Inviting people to stand, stretch, and turn around maybe enough to get the circulation going again.

FLIP CHARTS, OVERHEADS, AND OTHER AUDIO VISUALS

Gremlins love to play tricks on facilitators. They often hide in AV equipment, so it is best to be well prepared. Here is a list of handy hints.

Flip Charts

- print in clear, neat letters one and a half inches high in horizontal lines. If the group is larger than 30 people, print even larger.
- no more than 10 lines of information per page--do not crowd the printing.
- speak to the group, not the flip chart!
- put "cheat notes" in pencil ahead of time on the flip chart. This helps with examples, further explanations, difficult words to spell, etc. Then you can write in large letters for the group as you go along.
- post key sheets on the wall (e.g.: agenda, objectives, key points).
- put a brief title at the top of each page.
- use wide felt-tipped markers and print boldly. Avoid light or bright colors for printing (red, orange, yellow, pink). They can be used for underlining or marking items. Use deep and dark colors (blue, black, green, purple) for printing.
- do not use squeaky pens. You may lose half of the participants!
- avoid pens that have particularly strong odors. Many people have allergic reactions to these.

Overheads

1. Size:
   - use no more than six words per line, and six lines per image
   - select key words and phrases
   - use simple, bold lettering or diagrams
   - typewritten material needs to be bold and increased in size (you need to be able to read the original 8 to 10 feet away to ensure it will project large enough for the group)

2. Presentation:
   - keep the ideas simple
   - if you have a few items on one transparency, draw people's attention to a specific point by either setting a small pointer or pen on the transparency beside the item, or cover up all items except the one to which you are speaking
   - turn the projector off while changing transparencies or whenever you want to redirect the attention of the group away from the overhead back to you
   - make sure people can see the screen or move chairs so they can

Videos and Films

In using an entire video or film, or a portion, remember these tips.

1. Make sure the screen is large enough and high up enough to be seen by the entire group.

2. Check that the sound is neither too loud nor too soft.

3. Provide an introduction to the video:
   - what's the context?
   - do you want them to listen for a specific purpose? If so, you need to write this on flip chart or a handout.
   - let people know how long this will take.

4. Keep some light on in the room while viewing. Pitch darkness is hard on the eyes, and is not safe if a participant needs to move.

5. After the viewing, be clear about what the group is to do next.

A CHECKLIST ON CLIMATE SETTING

There are two aspects on climate setting to help people feel comfortable in the group.

1. **Psychological** - to help people feel they belong. This includes:
   - sending out notices of the workshop well beforehand
   - having kits or folders ready with participant's name and name tag. Make sure the name tags are done in large letters.
   - having someone on hand to greet people as they come, show them where to put their coats, and where to sit
   - during the workshop, use participants' own experience to make connections with the topic

2. **Physical** - to help people feel comfortable. This includes:
   - having chairs around small tables or in a circle so people can see one another.
   - ensuring there is a clear view of the front [flip chart, overhead screen, and of course the facilitator(s)].
   - making sure there are enough resource materials for each participant.

A NOTE ABOUT SPECIAL CONCERNS

1. Confidentiality

This may be an issue at your workshop you will need to talk about with the group and make some decisions about standards - what is OK and not OK to talk about beyond this workshop and with whom. People may also declare whether they want confidentiality around particular topics or stories they share.

2. Emotional Responses

Elder abuse is an emotionally laden topic. When people share stories or experiences of elder abuse it raises emotions. If/when this happens in a group, it's important to openly acknowledge the fact that emotional responses are natural, then move on as appropriate. Participants need to feel OK about the emotional content in talking about elder abuse.

WORKSHOP OUTLINES

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WORKSHOP OUTLINES

FULL DAY PRESENTATION - ELDER ABUSE

9:00 - 9:20	Introductions and Welcome
9:20 - 10:15	Introduction to Elder Abuse (Appendix I, p. 48) – Aging Awareness Quiz – Framing the Problem of Elder Abuse (Appendix I, p. 55)
10:15 - 10:30	Refreshments
10:30 - 11:30	Elder Abuse Defined and Described (Appendix I, p. 61 to 66)
11:30 - 12:00	Small Group Discussion/Questions – case study (Appendix III B, p. 125 to 136) or – guide questions (Appendix III C, p. 137 & 139) or – other at the discretion of the workshop leader(s)
12:00 - 1:00	LUNCH
1:00 - 2:00	Elder Abuse Defined and Described Contd (Appendix I, #6, p. 66 ...Why Does it Occur?) Theories on the Causes of Elder Abuse (Appendix I, p. 66 to 72)
2:00 - 2:30	NFB Video viewing and guided small group discussion using questions provided – "Elsie and Dorothy" and – "Mr. and Mrs. Mueller" (see Appendix I, p. 66 and Appendix III, p. 117 & 121)
2:30 - 2:45	Refreshments
2:45 - 3:10	NFB video viewing and small group discussion – "Margo" (see Appendix I, #6, p. 66 and Appendix III, p. 119 & 123)
3:10 - 3:55	Strategies for Intervention (Appendix I, #9, p. 75)
3:55 - 4:15	Closure, Evaluation and Adjournment

THREE HOURS (ONE-HALF DAY) PRESENTATION
- ELDER ABUSE

10 min.	Welcome and introduction (see "Designing a Workshop" p. 27 for ideas).
30 min.	Raising our Awareness: A Quiz on Aging and Elder Abuse (Appendix I, p. 48 to 54).
10 min.	What is Elder Abuse? Definitions and Description of Types of Abuse. (Use related overheads. Involve group by asking questions as in "One Hour Presentation").
10 min.	Who are potential victims of abuse and perpetrators of abuse (abusers)? What are high risk situations? (Appendix I, p. 64).
5 min.	How big a problem is elder abuse (Appendix I, p. 63).
35 min.	Causes of Abuse (Appendix I, p. 66 to 72). 1. Environmental Framework (Caregiver Stress) "Elsie and Dorothy" - eight minute vignette and eight minutes to debrief (Appendix III, p. 117 & 121). 2. Pathological Framework (Appendix I, p. 70).
15 min.	Break.
	3. Family Violence Framework Show "Margo", eight minute vignette illustrates both 2. and 3. (Appendix III, p. 119 & 123) - eight minutes to debrief
20 min.	Case studies - small groups with large group debriefing (Appendix III, p. 125 to 136).
45 min.	What We Can Do About Elder Abuse? (Appendix I, p. 73). First of all, why do we have so much trouble seeing it? What do we do when we do see it? What can we as community (society) do about elder abuse? (See handouts and overheads, Appendix IV, p. 145 & 147)

ONE HOUR PRESENTATION - ELDER ABUSE

5 min.	Introduction Elder abuse as a social issue, (Appendix I, p. 61) a form of family violence, not new but finally talked about, a very painful subject, one we are only beginning to learn about.
10 min.	What do we mean by elder abuse? Definition and description of types of abuse: (Use overheads and involve group by asking questions such as "What behaviors would you call physical abuse? psychological abuse? etc.)
10 min.	Who are the potential victims of elder abuse? (Appendix I, p. 64) Who are the potential perpetrators of abuse (abusers)? (Appendix I, p. 65) What are high risk situations? Use overheads for each question. Also use overhead on the Cycle of Violence (Appendix IV, p. 165).
15 min. or 20 min.	Why does abuse occur? (Appendix I, p. 66 and following) (two options are outlined). Option 1 - Explanation of the three theories with use of overheads, including overheads with quotations by M. Lezak and Steinmetz. Case studies can also be used to illustrate theories. Option 2 - Explain briefly the three theories using the eight minute vignette "Elsie and Dorothy," first vignette in the video "A House Divided" to illustrate the environmental framework (caregiver stress) and "Margo", the third (eight minute) vignette in the same video, to illustrate both the family violence theory and the pathological caregiver theory.
10 min.	What can we do about abuse? (Appendix I, #8, p. 73) (Use sections: "What Can We Do When We See Elder Abuse?", and "Strategies for Intervention").
5 min. or 10 min.	Questions and Closure

APPENDICES

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APPENDIX I

WORKSHOP CONTENT

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APPENDIX I

WORKSHOP CONTENT

The following information is offered as background material to the trainers conducting Elder Abuse Awareness Workshops. Trainers should feel free to use it in whatever way it is most helpful:

a) as background reading to prepare you for the workshop

b) as information necessary to your understanding of the issues.

Many workshop trainers are well versed in this area and may have collected their own perspective on the elder abuse phenomenon. The authors do not want anyone to assume that this kit is the final or only word on elder abuse. We refer you to Appendix VIII of this Module for a listing of references, readings and resources.

SECTION I

INTRODUCTION TO ELDER ABUSE: BUILDING THE CONTEXT

Many older Canadians enjoy positive relationships with their family and significant others. Within the memory of most of us, the "elders" - our grandparents, parents, aunts and uncles - were among the most valued members of society. Elderly people did, in most cases, look forward to an old age supported by the loving care of their extended family. Hopefully, this is true even today for many people as they age.

Nevertheless, there is growing awareness that some elderly Canadians suffer abuse in several forms, and the so-called "golden years" are filled with sadness and tragedy.

Elder Abuse has been identified as a significant social problem by both those working in the field of aging and those working in the area of domestic violence. Each group brings helpful perspectives to this complex issue.

The experience and knowledge gained with respect to other forms of family violence can be applied in dealing with elder abuse, although we cannot assume that all forms of family violence are similar or respond in the same way to particular intervention strategies.

INTRODUCTION TO: RAISING OUR AWARENESS

A QUIZ ON AGING AND ELDER ABUSE

Since elder abuse is perpetrated against persons over the age of 60, an understanding of this phenomenon requires some insight into the issues surrounding aging. This insight is informed by a review of the demographics of aging and recognizes the presence of ageism and/or myths which surround the aging process. A few of the common myths that society holds about aging are reviewed in the "Raising Our Awareness" quiz.

RAISING OUR AWARENESS:
A QUIZ ON AGING AND ELDER ABUSE

1. Most older people are physically weak and in poor condition. T F
2. Senility is a normal part of body breakdown. T F
3. Senile dementia is irreversible. T F
4. After the age of 65, the ability to learn is greatly diminished. T F
5. At least 15% of the aged are living in long stay institutions in Canada. T F
6. Older people today have less contact with their families than older people in the past. T F
7. The aging process causes people to become more self-absorbed and uninterested in others. T F
8. The majority of older people have incomes below the poverty level. T F
9. Elder abuse is a new phenomenon created by our modern society. T F
10. Elder abuse always involves physical contact. T F
11. The majority of elderly people complain about or report the mistreatment they receive. T F
12. The person who abuses an elderly person is not usually a family member. T F
13. Stress in the life of the caretaker is rarely a factor for precipitating abuse of the elderly. T F

Adapted from: Novak, M., Aging in Canada. Nelson, Canada, 1988.
(See Handout I a, p. 143)

RAISING OUR AWARENESS: A QUIZ ON AGING AND ELDER ABUSE

The use of this quiz may help you to deliver information about aging in a way that is fun and interesting. The quiz covers some popular myths about aging. The correct response is "False" in all cases (but don't tell your group that right away!). To assist in providing factual information to the group after you have reviewed the quiz, the following notes highlight the key points to make in correcting these stereotypical views of older people. Remember, education in general, and knowledge about aging in particular, can improve people's attitude toward aging.

1. Contrary to popular opinion, the majority of older Canadians are physically well. In a National Health and Welfare survey (1984), 78% of the respondents rated their health as "good to excellent". Another measure of the health status of older people is the inverse measure of mortality. Canada, like most Western countries, has experienced a sharp decline in mortality rates, indicating that older people are probably healthier now that in the past. However, there is no question that Canada's older population, at present, has higher rates of hospital utilization than the younger population. In Saskatchewan, people over the age of 65 make up 13.4% of the general population but are over represented in hospital utilization statistics (Weaver and Nilson, 1990). While no clear one-to-one relationship emerges between growth in the older population and dramatic increases in health care costs, studies suggest that Canada's commitment to the medical model, in which health care utilization is determined by physicians, accounts for much of the increase in health care spending. Therefore, the high hospitalization rates for seniors may be a result of the lack of alternatives to hospital admission such as home care and other community based services (Chappell, Strain, and Blandford, 1986; Gross and Schwenger, 1981).

2. "Senility" is a term which is greatly misused. Webster's dictionary defines senility as " ...showing marked deterioration often accompanying old age, esp. the mental impairment characterized by confusion, memory loss etc..." Many people often use "senile" solely to mean cognitive impairment. While it is true that some older people do suffer from cognitive impairment of varying degrees, the actual percentage of older people with impaired thinking processes is low. A study by Robertson, Rockwood, and Stolee (1982) in Saskatchewan found moderate to severe cognitive dysfunction in only 2.4% of people over the age of 65. The study

did suggest however, that rates of dementia increase with age (the study indicated that 29.9% of those over the age of 85 suffered some form of cognitive impairment).

3. Many older people with impairment to their thought processes are inappropriately labelled as suffering from "senile dementia" when little effort has been made to rule out reversible causes. There are a host of reversible physical conditions (delirium from anaesthesia or high fever, metabolic disturbances such as hypothyroidism, drug toxicity etc.) which, when treated, can return the older person to previous levels of cognitive functioning. Careful medical diagnosis is required to guarantee that helping professionals can reverse the reversible, treat the treatable and manage the chronic conditions of late life.

4. A great deal of research has been conducted on learning, memory and aging. Early research supported the myth that intellectual ability declines with age, but more recent research questions these findings. Studies show that younger people do perform better than older people on some memory and intelligence tests, but the pace of testing, the types of questions asked, motivation or interest in the testing process, and the way older people learn and use information can all decrease their performance. Tests that study knowledge utilization show that older people learn and use information as well as younger people in everyday life.

5. Although there are regional differences in the percentage of older persons living in institutions, the national average is 10.7% (Stats Canada 1986). Newfoundland, Quebec, Alberta and both Territories were below the national average, while the seven remaining provinces (including Saskatchewan at approximately 13.4%) were above.

6. The myth persists that middle-aged children abandon their elderly parents, but studies show again and again that children maintain their contact with their parents, provide help to them, and get help *from* them when they need it. As the section on family relationships will demonstrate, families are very much a part of the daily life of most seniors. Studies by Brody (1986), Rosenthal (1986), Chappell and Havens (1985) reported that over 80% of seniors living in the community identify family members as the providers of the bulk of the care and support they require.

7. It is no surprize that those individuals who have had life long patterns of being self absorbed and uninterested in others are unlikely to change as they age. However, the opposite is also true. Individuals who are outgoing, concerned and interested for and about others will continue to be that way, if the people in their social environment tolerate and invite such interaction. Older people do not necessarily disengage from life and social relationships, but circumstances for some people (illness, lack of transportation, social isolation) may limit or reduce their social circle and minimize the opportunity for them to be involved and connected to others.

8. Some people - very old women, people from lower income brackets, people with lower levels of education, widows and homemakers - all run a higher than average risk of poverty in old age. In 1983 "one elderly Canadian in four lived below the poverty level; about 71 % of these people are women" (National Council on Welfare 1985)

9. Although the abuse and neglect of elderly persons is thought *not* to be a new problem, it has existed in relative isolation and obscurity. Only recently has society begun to recognize the full extent of the problem and in turn, take some positive steps towards its prevention.

10. As information in this Elder Abuse Awareness Training Module will demonstrate, elder abuse takes several forms.

11. Due to the environmental context of most incidences of abuse, it is not often that elderly people report the abuse. A host of factors such as fear or retaliation, shame, guilt, loyalty to family or the abusive person, or a belief that the system will not respond, may be some of the reasons why elderly persons hesitate to report abuse.

12. Tragically, many incidences of abuse happen within the family environment. Rather than merely "blaming" the incident on individuals, an understanding of the social context, family dynamics and the various interpersonal and situational circumstances that can lead to potentially abusive situations is essential.

13. Families and other caregivers sometimes pay an emotional, physical, psychological, and financial price when involved in a caregiving relationship to an older person. The toils and strain of caring for an aging person may be added to other duties or worries. Excess responsibilities, unresolved personal issues and role overload may trigger a potentially abusive situation.

SECTION II

FRAMING THE PROBLEM OF ELDER ABUSE

A. The Social Environment

Elder abuse does not occur in a "social vacuum" but rather is a situation which occurs against a backdrop of societal values, societal structure, and social relationships. The phenomenon needs to be seen as a social issue with both a personal and an environmental dimension.

Researchers into the field of elder abuse are recognizing that one of the reasons it has been so difficult to grasp the social significance of this issue is based on the unhappy realization that society tends to act as though aged persons are insignificant and therefore their worries are of lesser importance than other sectors of society. Such ageist attitudes perpetuate a system of destructive, false beliefs about the elderly. A poor understanding of the process of aging and negative attitudes toward aging may be important factors in the development and tolerance of abusive and neglectful behaviors.

Living in an ageist world in which these negative attitudes toward older people are accepted can create an environment in which elder abuse may readily occur. This same set of circumstances also creates an environment in which the older person who is abused feels powerless to create change since this undervaluing of older people contributes to the development of low self acceptance and self worth.

One of the most perplexing questions which arises from the study of elder abuse is "Why do older people put up with this kind of treatment?" The work of two sociologists, J. Kuypers and V. Bengston (1973) helps to find a plausible answer to this question and explains the effect societal ageism has as a contributing cause of elder abuse. These same researchers suggest that ageist attitudes and conditions can be reversed and offer a model for societal reorganization (see Appendix VI Reading Resources, p. 183).

B. Family Relationships

Contrary to a popular myth, most older people in contemporary times are integrated into social and family networks with ongoing support and caregiving relationships. It is important to recognize that there didn't used to be a "later life". In 1900 the average life expectancy was 47 years of age. Life expectancy now reaches the mid-70's to early 80's. This dramatic increase in our own, our children's and our parent's life expectancy may be the single most important factor in changing the context of family issues over the past few decades.

Today, each family has to break new ground in caring for and about each other. There are few patterns or automatic guidelines of how to relate to and meet the needs of several generations. Only recently has the average family included grandparents and great-grandparents and these families are having to reorganize to deal with later life issues. Often this reorganization overwhelms the usual coping patterns that have sustained balance within the family units. So, while growing old can include the joys of living a full life, of activity and participation in new beginnings and having a warm and supportive circle of family and friends, for some late life may be hampered by conflict, vulnerability and abuse.

While the 1960's enhanced our awareness of the tragedy of child abuse, the 1970's and 80's of spousal violence, in the 1990's we are alarmed by reports of elder abuse. The recognition that such phenomena occur within the context of family relationships cannot be ignored. As reported by Steinmetz and Streus (1974) "it would be hard to find a group or institution in North American society in which violence is more of an everyday occurrence than it is within the family" (see Overhead II a, p. 149).

The abuse of the elderly in the private family setting is difficult for outsiders to identify. Elder abuse, like other forms of family violence, is generally hidden and emotionally charged. The vulnerable elderly are often more isolated from the mainstream of society than are children and younger adults. So while the abused child may be seen by a teacher or others and the abused spouse by neighbors and friends, it is often difficult for an elderly, sometimes frail, older person to alert people to the abuse.

When incidents of abuse are discovered, it is often too easy to lay all the blame at the feet of family members and label these family systems as unusual and "dysfunctional". Taking this position limits our understanding of the issue and restricts the view of elder abuse as a concern that happens only as a result of pathological family members or poor caregiving relationships.

It may be convenient to identify the issue of elder abuse as one which only happens in "bad" family relationships but doing so only serves to label as sick the family struggling with the effects of conflict and violence or neglect. This attitude chooses to ignore that any kind of violence is society's problem because it reflects society's values and how it deals with its less powerful members including children, women and the elderly.

For us to truly understand the issue of abuse, (whether it is the abuse of child, spouse or elder), it is essential that we recognize the complexity of most family relationships. We must recognize that families are "emotional systems", which must respond differently to the needs and desires of individual members of that family.

At any given point in time, families may become incapable of responding effectively to the competing needs of individuals members by becoming overwhelmed by environmental factors which limit or destroy the emotional bonds which may have existed. Alternately, there may be long standing interpersonal conflict or problems such as substance abuse or mental health concerns which complicate or constrain the family's ability to respond in a caring manner.

It must be noted that this presentation of multi-generational family systems is tainted with a cultural bias. We need to acknowledge that much of what we know in Canada today of how families operate is informed by a study of only the dominant culture. Many of the comments in this section may seem inadequate for those working with aboriginal communities or for families of new Canadians recently emigrated to this country. Significant efforts need to be undertaken to explore the effect of multi-generational relationships in these two important populations of Canadian society.

C. How Family Systems Operate

To unravel the complicated knot of circumstances which lead to incidents of abuse/neglect within family settings, it is essential that we understand how multi-generational families are structured and how they operate. Some of the concepts of how family systems work may help us to understand families generally and therefore be better able to understand families in distress. These concepts include:

1. Developmental Stressors - these are the changes that are part of the normal shift of the family system at the beginning of a new life cycle phase. For example, caring for an aging parent at the same time as caring for young or young adult children. It includes changes such as retirement or widowhood.

2. Homeostasis - all families develop methods which help to keep the family "in balance". When a crisis develops (perhaps due to a developmental or external stressors like illness), the extended family unit may find that the usual methods do not work to keep the family system balanced. This may be because these methods are inadequate to the task or because they are exhausted or over-extended. For example, a family, which includes grandparent as well as children, may function well as long as the main caregiver (usually the mother) is well. Should she become ill, the whole system becomes stressed, and may breakdown.

3. Loyalty - most family systems expect and develop a sense of loyalty to family members. The commitment (for better or worse) to family is one of the earliest bonds experienced. Dealing with the loyalty issue is essential in family relationships where abuse has occurred. There are many reasons why seniors are loathe to report abuse by a family member: fear, shame, guilt, etc. In addition, reporting a family member for mistreatment also can be seen to break the bond of family loyalty.

4. Family Rules - all families have rules (overt or covert) which prescribe the rights, duties, and range of appropriate behavior within the family unit. For example, in families where caregiver stress is present, it may be that the family system is resistant to the offer of outside supports due to a belief or rule that "families must look after their own". So while family rules may be beneficial to the family organization, rigid adherence to a rule which prescribes responsibilities of one family member for another may cause significant interpersonal conflict.

5. **Family Roles** - The family is the major arena in which social roles are learned. How a family adapts to role transitions test both the individual members and the unit as a whole. Much of the stress experienced by families which include older members is related to difficulties surrounding role transitions, dependency vs. autonomy, and role overload. Failure to resolve these issues may lead to interpersonal conflict and potential abuse.

6. **Secrets, Distortions and Myths** - Members of multi-generational families often have differing or distorted ideas or myths about "how families ought to be". Different views on the matter can lead to disagreements over family relationships and responsibilities. In addition, many family histories contain secrets which have been protected and hidden from public view. For example, one of the principal theories on the causes of elder abuse suggests that abusive relationships can exist over several generations and family members may learn that the only way to resolve interpersonal conflict is through violence or aggression. There is evidence that family members who abuse their older family members were abused as children. This family secret of multi-generational family violence can be seen to lie behind elder abuse.

7. **Communication** - Family members often have a difficult time talking to each other about emotional issues. The circumstances of having family members experiencing the issues of late life raises a number of concerns that need to be discussed freely and openly (e.g.: obtaining outside help, nursing home placement, dealing with the competing emotional and physical needs of a multi-generational family). Unfortunately, many families feel disloyal or ill-prepared to talk with each other and outsiders about their worries and concern. Failure to "talk over" some of the problems and possible solutions to caregiver stress or problems in family relationships may result in feelings of isolation and frustration. Such frustration may erupt in abusive behavior toward self or others.

8. **The Multi-Generational Perspective** - As has been said, families of today often comprise several generations, all of whom are at different developmental or life transition stages, and all of whom have needs and expectations of the other members of the family system. For example, the so-called "Sandwich Generation" is when the younger women is often stretched between the generations and has primary caregiving responsibilities in a number of different directions. The way family members relate to each, how they "give and take", and what they expect,

> often comes from learned trans-generational patterns and emotional experiences of life in the family unit. Some of these experiences, patterns, and expectations may spark an emotional "tug-of-war" for family members.

Many of the emotions which have existed between the members of an extended family remain the same, although the intensity and immediacy of them may have changed somewhat. These emotions can include love, compassion, tenderness and respect but may also include indifference, fear or anxiety, shame or guilt, anger or hostility or a mixture of all of these. Helping family members to sort through the maze of the emotional reactions or feelings toward an aging family member may go a long way to resolving interpersonal conflict and minimizing potentially abusive situations.

Far from being invisible and hopeless relics who are not connected to significant social relationships, people in the later life stage are engaged in family relationships that may nurture and sustain them or may frustrate or harm them. All family life has periods of ups and downs; of stress or worry.

SECTION III

ELDER ABUSE: IDENTIFYING THE KEY ISSUES

1. WHAT IS ELDER ABUSE?

Introduction

Elder Abuse is not a new phenomenon; something that is happening that did not happen in the past. What is happening today is that elder abuse has "come out of the closet". Today we are willing to talk about elder abuse, previously we were not. Elder abuse is a form of family violence - a difficult area for all societies to face - and like other forms of family violence, child abuse, spousal abuse, and sexual abuse, it is now the subject of research and policy deliberations. It has been studied, however, only since the late 1970's, many of the studies used small numbers, defined abuse differently, and their results could not be used to tell us how big a problem elder abuse is or what factors contributed to abuse.

It is important to realize that we are still in the process of learning about elder abuse, and that today we are revising what we thought we knew yesterday. Tomorrow's research will undoubtedly give us new insights that today we are unaware of.

Definition

There is no universally agreed upon definition of elder abuse. Researches have used different definitions in their studies and existing adult protection legislation in some Canadian provinces, and most American states use different definitions of abuse - some legislation does not define it.

In general, however, there is agreement that: **elder abuse is an act, committed or omitted, which results in injury or harm to the elderly person** (see Overhead III a, p. 151).

Elder abuse is studied within the context of family violence. Abuses perpetrated (committed) by non-family caregivers usually in non-family living and caregiving situations are included in elder abuse. Abuses perpetrated by persons who are neither family nor caregivers are viewed as victimization and within the context of civil or criminal laws.

2. TYPES OF ABUSE

It is important that we recognize the behaviors that are considered abusive. Let us look at each type of abuse in detail. (See Overhead III b, p. 153)

a) **Physical Abuse** or the infliction of physical discomfort, pain or injury. It includes behaviors such as: slapping, hitting, punching, beating with hand or instrument, stabbing, shooting, burning, sexual assault, physical coercion, handling roughly, and medical maltreatment. The use of physical restraints are considered by some to be abusive if used at all, by others if used for long periods of time.

b) **Psychological Abuse**, sometimes called emotional abuse, and in the National Survey of Abuse of the Elderly in Canada, "chronic verbal aggression". It is the infliction of mental anguish or the provocation of fear of violence or isolation. It diminishes the identity, dignity, and self-worth of the elder. It includes behaviors such as: name calling, yelling, insulting, threatening, imitating, swearing, infantilizing (treating like a child), ignoring, isolating, excluding from meaningful events or activities, excluding from decision making when the elder is capable and wants to be included and deprivation of rights.

c) **Material Abuse** also known as financial abuse is the theft or misuse of money or property. It includes behaviors such as: attempts to persuade, trick, or threaten the elder out of money, property, or possessions; attempts to influence their Will; cashing of pension or other cheques without authorization and use of the elder's money for purposes other than intended by the elder.

Some seniors are preyed upon by unscrupulous sales or trades people who overcharge for goods or services. The vulnerability of the seniors selected for this form of abuse or victimization is recognized and exploited by the perpetrators. Such abuse is a violation of the Criminal Code and these situations ought to be brought to the attention of the local police force.

d) Neglect is the failure of a caregiver to meet the needs of an elder who is unable to meet them him or herself. Some studies differentiate between active or intentional neglect, and passive or unintentional neglect. Neglect includes behaviors such as denial of: food, water, and or medications; medical treatment; therapy; nursing services; therapeutic aids and equipment aids; clothing; visits from people important to the elder; and rights.

3. HOW BIG A PROBLEM IS ELDER ABUSE?

Differences in definitions of abuse or types of abuse in research have resulted in different reports on the frequency with which abuse occurs and, therefore, on how big a problem it is.

The most frequently quoted study in Canada today is the National Survey on Abuse of the Elderly in Canada (Podnieks, 1989). Two thousand randomly selected elderly Canadians living in private dwellings in all regions of Canada were interviewed by telephone. (See Overhead III c, p. 155)

The survey found that 4% reported one or more forms of abuse. Researchers believe that their findings can be used to estimate the rate of abuse among elderly Canadians living in private homes. Four percent of Canadian elders means that approximately 98,000 Canadian seniors have or are experiencing abuse.

The survey found that material abuse was the most frequent type of abuse reported, and estimates that 2.5% of Canadian seniors, that is about 60,000 Canadian seniors, have experienced some form of material abuse.

Chronic verbal aggression was found to be the second most common form of abuse with 1.4% reporting it. That means that 34,000 Canadian seniors experience this form of abuse. The survey also claims that if denial of access to grandchildren had been included as abuse, the overall rate of abuse would have jumped to 7%.

Physical abuse was reported by .5% of those surveyed. This means that approximately 12,000 Canadian seniors are victims of physical abuse.

The survey found that .4% of Canadian seniors, or 10,000 seniors, have experienced neglect.

The survey also found that the rate of elder abuse on the Prairies (approximately 3% of 4,000 seniors) is somewhat less than in other parts of Canada.

It is important to remember that some elders experience more than one form of abuse, that psychological abuse can escalate into physical abuse, and that abuse can flow both to and from the elder to a family member or non-family caregiver.

Abuse is believed to cross ethnic, social and socioeconomic lines. It used to be considered as happening only in lower socioeconomic situations, but that is a false assumption. (See Overhead III d, p. 157)

Some forms of abuse may be criminal wrong-doings.

4. WHO ARE THE VICTIMS OR POTENTIAL VICTIMS OF ELDER ABUSE?

(See Overhead III e, p. 159)

Earliest research pointed to the frail elderly who are:

a) very old
b) usually female
c) physically and/or cognitively impaired
d) dependent on others to perform basic tasks necessary for daily living
e) usually poor

More recent research shows that some elderly people who are not frail also experience abuse. This is particularly the case if family violence had been a pattern before the person became elderly. Some elder abuse has been found to be "spouse abuse grown old".

Characteristics of the caregiver such as substance abuse are now suspected to be more important predictors of elder abuse than characteristics of the elderly victim or potential victim.

5. WHO ARE THE PERPETRATORS OR POTENTIAL PERPETRATORS OF ELDER ABUSE?

(See Overhead III f, p. 161)

Abuse of the elderly relatives has been committed by spouses, adult children (both daughters and sons), siblings, and other distant relatives. More recent research implicates spouses most probably because more spouses than adult children live with the elder. The personal problems of the abuser are now receiving more attention as possible indicators of abuse, particularly substance abuse.

Other factors believed to contribute to potential abuse include: isolation, both geographic and social, lack of knowledge about aging and the elder's health and needs, lack of preparation for caregiving skills and aids, and lack of support, either because it is unavailable or unacceptable.

The highest risk situations are those in which there is alcohol or other substance abuse, a history of family violence, or the caregiver is expressing frustration, threatening punishment, or whose resources cannot meet the needs of the elder.

Research has also found that caregivers in institutional settings can be potential perpetrators of abuse. Several Canadian and American studies of health care workers have found that 10% of respondents have reported that they have physically abused a resident (Gnaedinger, 1989). A further 40% reported that they had, at times, been psychologically abusive (Gnaedinger, 1989).

Though all staff can be abusive to residents, it is the "hands on" staff who have the greatest contact with residents and who may display abusive behavior. Unfortunately, these individuals have often been given very little opportunity to learn about the aging process, the effects of health problems on abilities and behavior, and on the stresses of being a formal caregiver. Heavy resident/staff ratios are the norm, the work is demanding and staff are often subject to caregiver stress.

Senior staff and administration of care homes have a responsibility to set out clear expectations for supportive, non-abusive relationships between staff and residents. The issue of elder mistreatment within the institutional setting is becoming recognized an new initiatives are being developed to deal with it. For example, the Saskatchewan Inter Hospital Committee on Domestic Violence has recently been awarded a federal Health and Welfare grant to develop educational programs for institutional staff.

6. WHY DOES ELDER ABUSE OCCUR?

The study of elder abuse is relatively new, and we are just beginning to learn why it occurs. It is important to learn the reasons elderly people are abused so that we can find ways to prevent it from happening, and ways to help those to whom it has happened.

Current theories explaining contributing factors of elder abuse can fit into three general categories or frameworks:

The Environmental Framework - in which the dependency of the elder and the stress of the caregiver are emphasized.

The Pathological Framework - in which pathological or "problem" characteristics of the abuser are viewed as the primary cause of the abuse.

The Developmental Framework - in which use of force and violence within families is viewed as learned behavior and thus an abused child learns to react with violence to those under his or her care.

We shall examine these frameworks in greater detail. (See Overhead III g, p. 163)

THEORY #1 THE ENVIRONMENTAL FRAMEWORK - CAREGIVER STRESS

The stress of giving care to very dependent elderly relatives is recognized as a key factor in some situations in which elderly people are abused by their caregivers.

Research has also pointed to the toll exacted on the caregiver in terms of both the physical and mental health problems including low self-esteem, depression, and anxiety. Caregivers have been described as waiting in the wings to become patients themselves.

Some caregivers are now willing to share some of their difficulties and feelings of frustration, and to describe situations in which they have found themselves losing control and acting in abusive ways. (See Appendix VI p. 195, "Potential for Abuse of Alzheimer Victims is Great" Alzheimer Rapport, Vol. 11/No. 3/Fall, 1988).

It is important for our understanding of elder abuse that we understand what is involved in caring for an elderly dependent relative, and some of the stressful experience.

1) WHO ARE CAREGIVERS?

Elderly people needing help turn first to their families. The spouse usually assumes responsibility for many of the household tasks the partner previously performed and sometimes for personal care as well. Often an adult child, usually living in a separate household, provides moral support, companionship, and practical assistance to both parents.

A high percentage of elderly, especially elderly women, are widowed and often living alone. They turn to an adult child, usually a daughter or daughter-in-law living in the same area. Some sons provide assistance, particularly if there is no female relative available. Though sometimes adult children share in the provision of assistance to their parent, usually one emerges as chief caregiver, at times with no help from the others, at times with considerable backup help.

Those who have no children turn to siblings, siblings' children, or cousins. Friends and neighbors can also be important sources of help.

Some elderly who have no family or whose families are unable to provide all the assistance they need live in institutions (called special care homes in Saskatchewan), and in private care homes (homes in which people pay the operator to provide room, board, and care). The staff of private care homes, who provide care to the residents, are also caregivers. They are mostly untrained or trained-on-the-job, have heavy workloads, low status and receive low pay.

2) WHAT DO CAREGIVERS DO?

In many families helping one another is a way of life. As one becomes less able, the pattern of helping changes from mutual to one-directional. Support usually starts with one or two specific time-limited tasks such as driving to shop, bank, and medical appointments. Over time the amount and type of help can increase, either because the elder's health has changed or because he or she requests more help as a way of increasing family visits. Usually help is required first with the so-called instrumental activities of daily living: banking and business, shopping, transportation, and household tasks (including cooking). Help with basic activities of daily living such as eating, toileting, dressing, hygiene, and mobility becomes necessary for some.

Some elderly who have dementia may require supervision often on a round-the-clock basis because they are no longer able to make decisions that keep them safe. They may not be able to find their way home if they go out alone, they may no longer recognize the dangers of roads and vehicles, the need for warm clothing, frigid temperatures, etc.

3) WHAT MAKES CAREGIVING SO STRESSFUL?

(See Overhead III i, p. 167)

Caregivers report that it is not so much the specific assistance that they give as it is the emotional "wear and tear" that causes stress. They feel tied down, unable to get away, unable to look after the needs of other family members or their own and they may lack privacy.

Some care needs, however, have been found to be particularly stressful. These include urinary and bowel incontinence, night disturbance and aggressive behavior.

Providing care to relatives with dementia is recognized as being particularly stressful. Dementia changes the affected person's intellect, personality, behavior, and relationships. Family members feel they are losing or have lost the relative they value, even though the person is still there. At the same time, they have to provide round-the-clock care. A book written for family caregivers of Alzheimer patients entitled "The Thirty-Six Hour Day" describes the plight of families.

Dr. Muriel Lezak, an expert in the field of brain injury, states that "one who has not cared for an ill, helpless, confused, old person may not comprehend the helplessness, rage, and frustration involved." Recent research into elder abuse found that 81% of caregivers living with or caring for a relative with dementia believe that they could become violent.

Difficult family relationships add stress to caregiving. Often the adult child providing care is not the favorite one or the one to whom the elderly parent feels closest. Sometimes the efforts of the caregiver are overlooked or criticized, while the virtues of the favorite or absent children are praised. Rivalries and jealousies between siblings, sometimes unresolved from childhood, complicate matters and result in a lack of sharing in the provision of help and in reliance on one family caregiver.

Lack of support from other family members or community support services contributes to exhaustion and stress. Sometimes the lack of support occurs because it is unavailable, sometimes because it is unacceptable to the elder or his/her caregiver.

Isolation of the elderly person receiving care is a major factor in abuse situations. This is particularly of concern to a rural province such as Saskatchewan.

Some caregivers are coping, not only with providing care to their elderly relative, but with problems of their own. Spouses are usually elderly themselves, adult children are sometimes in their sixties or seventies and dealing with health problems of their own, their spouse or siblings. Others have family problems, experience unemployment, housing or financial problems. Still others have problems related to substance abuse. Alcohol abuse is now recognized as a major risk factor for elder abuse.

Note to Facilitator

Use of the first vignette, Elsie and Dorothy, in the video "A House Divided", produced by the National Film Board, is recommended for use in teaching about caregiver stress. This eight minute vignette shows the difficulties Elsie and her family experience in providing care for their Aunt Dorothy as her health fails, the crisis that results, and the difficult decisions that must be faced (see Appendix III, p. 117. See also discussion questions on p. 121).

THEORY #2: PATHOLOGICAL FRAMEWORK - THE PATHOLOGY OF THE CAREGIVER

(See Overhead III g, p. 163)

Research has found that having "problem" relatives is a major risk factor in elder abuse. Alcohol abuse in particular is now recognized as an important contributing factor and predictor of abuse potential.

The risk of abuse is also considered significant in situations in which the elder begins to require care from an adult child, who has lived much if not all of his/her life with parents because he/she was unable to manage alone. Included in this group are adult children who are mentally challenged; have disabling mental illness; experience significant losses due to illness or accident; are alcohol or other substance abusers; have social problems such as unemployment, inadequate income and poor relationship skills. In these situations the dependency on the family caregiver for basic necessities such as income and housing is seen as significant, if not more significant, than the dependence of the elder.

Note to Facilitator

The third vignette Margo, on the video, "A House Divided" is recommended to teach about physical abuse resulting from a son's alcoholism. Margo, 73, is in poor health, and lives near the poverty line. Her faith in her son persists despite his beatings when drunk (see Appendix III, p. 123).

THEORY #3: THE DEVELOPMENTAL FRAMEWORK - FAMILY VIOLENCE

(See Overhead III g, p. 163)

This framework views abusive behavior as learned behavior passed down from one generation to another. The child learns from his/her parent to react with verbal abuse, and with the use of force in certain situations. Situations that may give rise to such behavior include the settlement of family disputes, and the control of behavior deemed unacceptable. The child may learn to react with abusive behavior to situations that causes him/her to feel frustrated, having never learned appropriate skills to deal with the causes of frustration. The child incorporates these behaviors into his/her personality and continues these behaviors as an adult. Thus, the child treated with abuse may learn to become abusive.

It is important to recognize that:

a) not all families in which elder abuse occurs have a history of family violence

b) not all abused elders were abusive parents

c) not all perpetrators of abuse (abusers) were abused as children

d) not all abused children grow up to abuse their own children, their parents, or elderly people entrusted to their care

The assumption on which the developmental framework is based suggests that abusive behavior is learned by children from their parents and passed down form one generation to the next. Children learn from their experiences with the family to react to frustration with anger. Rather than learning skills to respond to frustration, anxiety or sadness in a healthy manner, these individuals may have developed an emotional repertoire which is limited to verbal or physical aggression. As children grow into adulthood, this inability to successfully respond to conflict can become ingrained or habitual.

It is important to remember that not all children who have been abused become abusive adults or that not all abusive adults were abused as children. Like many theories, the assumptions behind the Developmental Framework are only a beginning step in helping us to attempt to understand the complex emotional web which leads to interpersonal relationship problems.

It is also important to recognize that society seems to sanction the use of force within the family in certain situations. The family is the basic unit in society and is charged with the responsibility of caring for, providing for, and teaching its members. The old adage, "spare the rod and spoil the child" reminds us that the use for force has been regarded over the centuries as an important method of teaching children to behave appropriately, of controlling behavior, and of settling disputes. Today some people are questioning these practices and advocating non-violent methods of child rearing.

The developmental theory becomes dangerous if we use it to stereotype those experiencing abusive situations or to separate "us" from "them".

It is useful because it illustrates that lack of love is not the underlying cause of abuse (strong ties of love and affection are often felt between members of abusive families). It does, however, point us in an important direction in working with families to help them with frustration control and anger management.

Note To Facilitator

You may wish to show the video vignette about Margo ("A House Divided") at this point in the workshop. This vignette illustrates the Family Violence and Developmental Framework (see p. 119 and 123). Also, you may wish to use the overhead on the Cycle of Violence to illustrate this theory (see Overhead III h, p. 165).

7. WHAT ARE THE BARRIERS TO IDENTIFYING ELDER ABUSE?

a) Why Don't the Abused and Abusers Report It?

(See Handout III a, p. 145, and Overhead III j, p. 169)

1) Victims of abuse and the perpetrators of abuse rarely tell us. Why?

- because of feelings of shame, embarrassment, and disloyalty
- because of beliefs that they "get what they deserve", that their relative would not "do that" if they had behaved "better", that their problems are unsolvable
- because of fears of reprisals, of family break-up, of consequences such as a move to a nursing home, of exposure as a "bad" spouse or parent
- because of low self-esteem and lack of assertiveness
- because of cognitive impairment and resulting lack of recognition of abuse, inability to tell others and skepticism on the part of those told about the accuracy of their account.

b) Why Haven't We Seen Elder Abuse?

(See Handout III a, p. 145, and Overhead III k, p. 171)

1) If elderly people have been abused over the years, why haven't we seen it?

- * we assume that since the elder does not tell us, that it either does not happen or the elder consents to it.
- * we find it so painful. Facing elder abuse brings us face-to-face with our cherished beliefs about families as loving and nurturing. It is difficult for us to see that intense feelings of love go hand-in-hand with intense feelings of frustration and anger. It is difficult for us to accept that "violence is a everyday occurrence" in families, and that the use of force in certain circumstance and by certain individuals within the family has been sanctioned by societal beliefs.
- * we need to "sharpen our index of suspicion", to become aware of the potential for abuse, and to develop a level of comfort in discussing abuse.

8. WHAT CAN WE DO ABOUT ELDER ABUSE WHEN WE DO SEE IT?

(See Handout III b, p. 147)

In Saskatchewan there is no mandatory reporting of suspected cases of elder abuse.

There is no mandatory access to the alleged victim. Access depends on the willingness of the alleged victim and when the influence of the alleged perpetrator is great, (as is often the case) on the agreement of the alleged perpetrator.

Relationships with the alleged victim and perpetrator are therefore key to access. Visits by other people such as family members, friends, neighbors, clergy, health and social service personnel are necessary to break down the isolation that has been found to be so much a part of abuse situations.

A non-judgemental attitude on the part of the friend , health worker, or social service worker is essential in order to build a relationship with suspected abuse victims and families.

There is no legal framework for health and social service agencies to investigate or intervene in cases of elder abuse. Abuse that is a criminal act can be reported to the police. Police do not investigate third party reports, but such reports may be helpful to police in future incidents. If the victim reports to the police, that person decides whether or not the police proceed with an investigation.

The right of the elder to autonomy and to make decisions as the individual sees fit, is the cornerstone of interventions by health and social service agencies. Goals are to prevent abuse and to attempt to alleviate the conditions that contribute to the possibility of abuse. The focus is on the total situation rather than on the acts of abuse. Attention is paid to the alleged elderly victim, the alleged perpetrator, the wider family system and the available community supports.

Assessment is made on the elder's dependence with a view to improving his/her functioning if possible. Referral to health services that can contribute to improvement and maintenance of functioning is encouraged. Helpful services include geriatric assessment units, day hospitals, day centers, community and outreach therapy, and Home Care.

Factors contributing to abuse are also assessed and services offered to decrease these. Attempts are made to break the isolation of the victim (or potential victim) by increasing visits to the home and outings by the elder to family, neighbors and agencies. Support is offered in terms of respite, for example: respite beds in nursing homes, day center attendance, Home Care attendant services as well as input from other family members if possible. Counselling about the elder's health condition, ageing, care needs, caregiving, family relationships, anger and stress management is also offered. Other areas of stress and concern affecting the caregiver are also discussed and referrals made--if the caregiver is in agreement--to appropriate services.

Interventions should be the least restrictive and intrusive. Removal of the elder from home is a last resort. It brings additional losses to the elder and seems to punish him/her for being abused or neglected. If the elder must be removed from home because the individual is at grave risk or because family members agree that alternative accommodation and care must be found, attention must be paid to the relationships of the elder with the family including the alleged perpetrator and ways found to help everyone deal with the inevitable feelings of rejection and sadness. Family relationships usually matter most to the elderly and all efforts must by made to sustain and support them.

9. STRATEGIES FOR INTERVENTION - A LOOK AT COMMUNITY RESOURCES

(See Handout III b, p. 147)

During the course of the workshops, participants may wish to discuss some solutions to this problem. Outlining for your group the community resources which currently exist in your area would be a good way to start the discussion. Resources will, of course, vary from urban to rural centers and from one area of the province to another. Some resources participants in the workshop may be interested in include:

a) Home Care
b) Family Service Agencies, Regional Social Workers etc.
c) Police
d) General Practitioners, Hospital Personnel
e) Lawyers, Legal Aid, Law Society
f) Other

It is probable that your review of the current service network will lead the workshop participants into a discussion of other resources that are needed but perhaps not readily available to deal with this complex issue. The following comments are designed to help you to facilitate group discussion on this topic.

Experts in the field agree that elder abuse is a complex issue for which there are no easy answers or quick solutions (Breckman and Adelman 1988, Steinmetz, 1988, Matlaw and Mayer, 1986). Such a multidimensional issue requires multidimensional responses. It is clear that both the abused and the abuser require assistance. Intervention needs to be based on a restorative rather than a strictly punitive model, particularly in situations involving family constellations. Because the type and circumstances of abuse or neglect are varied, a variety of strategies are required. Some ideas to consider include:

1. Information and Training - Programs designed to increase community awareness and the ability of both lay persons and professionals to identify elder abuse is an important first step. Educational programs to teach caregivers (both in the informal and formal network) how to deal with stress and interpersonal conflict before it leads to abuse will also help. Caregiver support groups have been found to be of great assistance as "safety valves" to relieve the pressure which can come from the toils and strain of caregiving.

More public and professional awareness could lead to earlier reports and support. Seniors also need easy access to information about resources available (e.g.: Power of Attorney, consumer rights, counselling and family supports, enhanced health care, etc.).

2. Environmental Supports - The National Advisory Council on Aging (1991) suggests that "the best strategy for dealing with elder abuse is to prevent it by supporting the autonomy, independence and quality of life of seniors, both in the community and in institutions". To foster independence and autonomy as a strategy for combating elder abuse, change must take place. Improved income security, assistance with the activities of daily living (a broad range of home supports), accessible transportation and health and social service programs sensitive to the needs of an aging population are required.

3. Support Services for the Abusers/ Potential Abusers - The interactive nature of family violence based on a restorative rather than punitive model of intervention suggests that help for the perpetrators of mistreatment of elderly persons needs to begin. Easily accessible counselling programs for help with problems of addictions, unemployment or financial concerns, role overload and caregiver stress are needed. Training in anger management, coping and life skills can be offered to the abuser with psycho-social problems. Conjoint therapy, family counselling and/or support groups are a resource in cases of "spousal violence grown old". For the stressed caregiver, respite and day care services are essential. Modifying work schedules to reduce conflict and competition between the pressures of employment and caregiving may be beneficial for some.

4. Legislative Change - changes in family law have been suggested to facilitate ease of reporting and investigation of abuse. In most cases in Canada the abused person has to give permission before a professional can look into suspected abuse. Professionals often fear they will get sued by abusers for libel or slander. In the Atlantic provinces, adult protection legislation has been developed to permit investigation and intervention. This is important but the effectiveness of adult protective legislation has been criticized (Gordon et al, 1991; Gordon and Tomita, 1990) as violating the rights of mentally competent adults to choose how they want to live, no matter what the "risk factor". Whatever the criticism, much more work needs to be done on legislation concerning Enduring Power of Attorney,

mental competency, guardianship and family violence to improve the legal framework for protecting vulnerable individuals.

5. More Knowledge - effective intervention in the area of elder abuse and family violence requires more focused research. The causal theories of elder abuse need to be verified in order to design models of intervention which will work. How families operate and organize themselves in reference to the needs of several generations needs to be explored further. The prevalence, type and possible causes of elder abuse in aboriginal and new immigrant groups needs to be studied in an effort to find similarities or differences between the experience of these groups and the dominant culture. There is much yet to learn.

   Such study must be solidly based in the community rather than the academic community. Ownership of both problem and solutions belong to the community and efforts must be made to minimize the tendency to "pathologize" those affected by removing the issue or the people from the social, economic and community setting.

   Research and planning based in the community could lead to a community development approach which would build additional support networks for individuals and families. Through discussing the issue in the community setting, perhaps communities will become more caring and all members more involved in creating a society which minimizes violence in human relationships and maximizes respect and dignity for all.

APPENDIX II

FACILITATOR NOTES TO ACCOMPANY WORKSHOP CONTENT

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APPENDIX II

FACILITATOR NOTES TO ACCOMPANY WORKSHOP CONTENT

To assist you in presenting information concisely and clearly, the following notes are summaries of the "key points" from **Appendix I, Workshop Content**. The notes cover the same material in the same order as does the Workshop Content. They are to serve as your notes to help you in your presentation.

FACILITATOR NOTES

SECTION I

INTRODUCTION TO ELDER ABUSE: BUILDING THE CONTEXT

1. Demographic trends indicate a continued growth in the percentage of persons over the age of 65.

2. There is growing awareness that many older Canadians suffer abuse of many forms.

3. Myths about the Aging process abound and need to be addressed. Use the **AGING AWARENESS QUIZ** (Handout I a, p. 143) to highlight the following points (these correspond to the numbers on the quiz):

a) The majority of older people are physically well and remain active.

b) "Senility" is a term that is misused and the percentage of persons over the age of 65 who suffer from cognitive impairment is relatively low.

c) Suspected "senile dementia" needs to be thoroughly examined and reversible causes of cognitive impairment dealt with.

d) Recent research shows that the pace and the way older people learn and use information can affect their performance on traditional memory and intelligence measurement tools.

e) The national average of older persons who are institutionalized is approximately 10.7% although Saskatchewan's average is slightly higher.

f) Studies show that children maintain regular contact and provide much support to elderly family members.

g) Life long patterns of social interaction do not change - those who have been interested in others will likely continue to be, and those who haven't will likely not!

h) In 1983 about one in every four elderly people lived in poverty, approximately 2/3 were women.

i) Elder abuse has existed in relative isolation due, in part to insufficient reporting.

j) Elder abuse takes several forms. (See Appendix I, p. 62)

k) Elderly people tend not to report abuse for many different reasons.

l) Many incidents of abuse happen within the family environment.

m) The toils and strains of caregiving may lead to caregiver stress and be a contributing factor to elder abuse.

4. Elder abuse does not occur in a social vacuum but needs to be seen against a backdrop of social values, social structure and social relationships.

5. Living in an ageist world in which negative attitudes toward older people are accepted can create an environment in which elder abuse may occur and be tolerated. (See notes on Social Breakdown Syndrome, Appendix VI, p. 183)

6. Multi-generational families are a new phenomenon to society. There didn't used to be a "late life".

7. Many seniors are well integrated into family and social relationships which nourish and sustain them. Others experience family and social relationships which are laden with conflict and abuse. The recognition that elder abuse occurs within family relationships cannot be ignored.

8. The vulnerable elderly are often more isolated from the mainstream of society.

9. While it may be convenient to identify the issue of elder abuse as one which only happens in "bad" families, doing so only serves to pathologize (identify as "sick) the family and limits our view of the problem.

10. Family violence needs to be accepted as a societal problem because it reflects societal values about the worth of it's less powerful members - women, children and the elderly.

11. Much of what is known about family violence and family relationships is tainted with a bias from the dominant culture. More study is required to understand these issues from the perspective of aboriginal and new immigrant groups.

12. To unravel the complicated knot of circumstances which lead to elder abuse in family relationships it is important to have some understanding of how multi- generational families operate. (See Appendix I, Family Relationships, p. 56 & 57).

FACILITATOR NOTES

SECTION II

FRAMING THE PROBLEM OF ELDER ABUSE

A. The Social Environment

1. Elder abuse occurs in the context of society's values, structures and relationships.

2. Society tends to treat elderly persons as insignificant and, therefore, whose needs are less important than those of other groups.

3. Negative attitudes may contribute to the tolerance of abusive and neglectful behaviors toward the elderly.

4. Older people often feel powerless to create change since negative attitudes of society contribute to their feelings of low self-esteem.

B. Family Relationships

1. Most older people live in an integrated network of family support and caring relationships.

2. Increasing life expectancy has a major impact on family issues.

3. The current challenge of society and families is how to cope with and care for several generations at one time.

4. During the late 80's and early 90's, awareness of elder abuse has increased dramatically.

5. Violence within the family is a regular and common occurrence. Elder abuse is more difficult to identify because:
   a) It is usually hidden - elders are often isolated, and not active in public life.
   b) It is an emotionally charged issue involving fear, anger, frustration, and helplessness.

6. Elder abuse is a complex issue, the causes of which are many. It can occur in any family no matter how "healthy" or "sick" it is.

7. Long standing family problems such as conflict, substance abuse, or mental health concerns may increase the vulnerability of elderly to potential cause.

8. Families are "emotional systems". Each member has different needs. Sometimes these needs are in competition with each other. Sometimes the emotional needs in a family are greater than the capability to meet those needs.

C. How Family Systems Operate

The following are key concepts to help understand how the family system works.

1. **Developmental Stressors**
   Stress that occurs as part of movement of family members from one life stage to another (e.g.: the "sandwich generation" - caring for children and caring for an aging parent at the same time).

2. **Homeostasis**
   The way families try to keep in balance.

3. **Loyalty**
   How families bond themselves together. These ties are formed early on in life. They are a source of strength, but may also prevent family members from reporting mistreatment.

4. **Family Rules**
   These are named and unnamed. They define what is permissible and not permissible behavior (e.g.: families may resist seeking outside help because of the rule that "families must care for their own").

5. **Family Roles**
These govern decisions about who does what, and how much independence is allowed (e.g.: it may be expected that caregiving is mainly the woman's responsibility).

6. **Secrets, Distortions, Myths**
Differing ideas of family members about "how families ought to be". Hidden family secrets that are not told to the public (e.g.: "solving problems through physical violence").

7. **Communication**
Refers to how open or closed is a family's communication. Many families find it hard to talk about aging, and its possible implications for change in the aging person's life.

8. **Multi-Generational Perspective**
How do the generations in a family interrelate? Is there "give and take"? Emotions among generations include the full range from love and caring to indifference and hostility.

SUMMARY:
Family relationships may nurture and sustain or frustrate and harm the aging family member. Elder abuse occurs within the context of social relationships and, therefore, needs to be dealt with as a social issue.

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FACILITATOR NOTES

SECTION III

ELDER ABUSE: IDENTIFYING THE KEY ISSUES

1. WHAT IS ELDER ABUSE?

Introduction:

- not a new phenomenon
- more openness and publicity today
- a form of family violence
- studies on elder abuse date back only to the late 70's
- learning about elder abuse is ongoing

Definition:
(See Overhead III a, p. 151)

- no universally agreed upon definitions
- general agreement on the definition: "Elder abuse is an act committed or omitted, that results in injury or harm to the elderly person."
- when committed by neither family nor caregiver elder abuse is viewed as victimization within the context of civil or criminal law.

2. TYPES OF ABUSE

It is important that we recognize the behaviors that are considered abusive. Let us look at each type of abuse in detail. (See Overhead III b, p. 153)

a) **Physical Abuse** or the infliction of physical discomfort, pain or injury. It includes behaviors such as: slapping, hitting, punching, beating with hand or instrument, stabbing, shooting, burning, sexual assault, physical coercion, handling roughly, and medical maltreatment.

The use of physical restraints are considered by some to be abusive if used at all, by others if used for long periods of time.

b) **Psychological Abuse**, sometimes called emotional abuse, and in the National Survey of Abuse of the Elderly in Canada, "chronic verbal aggression". It is the infliction of mental anguish or the provocation of fear of violence or isolation.

It diminishes the identity, dignity, and self-worth of the elder. It includes behaviors such as: name calling, yelling, insulting, threatening, imitating, swearing, infantilizing (treating like a child), ignoring, isolating, excluding from meaningful events or activities, excluding from decision making when the elder is capable and wants to be included and deprivation of rights.

c) **Material Abuse** is the theft or misuse of money or property. It includes behaviors such as: attempts to persuade, trick, or threaten the elder out of money, property, or possessions; attempts to influence their Will; cashing of pension or other cheques without authorization and use of the elder's money for purposes other than intended by the elder.

d) **Neglect** is the failure of a caregiver to meet the needs of an older person who is unable to meet them by him or herself. Some studies differentiate between active or intentional neglect, and passive or unintentional neglect.

Neglect includes behaviors such as denial of: food, water, and or medications; medical treatment; therapy; nursing services; therapeutic aids and equipment aids; clothing; visits of people important to the elder; and denial of rights.

3. HOW BIG A PROBLEM IS ELDER ABUSE?

a) No standard way of measuring or reporting cases of elder abuse.

b) Results of telephone survey of 2,000 randomly selected elderly Canadians living in private dwellings (Podnieks, 1989). (See Overhead III c, p. 155)

* 4% reported one or more forms of abuse
- this means 98,000 Canadian seniors are experiencing some form of abuse.

- 2.5% reported material abuse or 60,000 people.
- 1.4% reported verbal abuse or 34,000 people.
- 7% reported denial of access to grandchildren.
- .5% reported physical abuse or 12,000 Canadians.
- .4% reported neglect or 10,000 seniors

NOTE: This survey only measures self-reported incidences by seniors who are living in their own homes, and who were willing to provide information.

c) Some seniors experience more than one form of abuse.

d) Psychological abuse can escalate into physical abuse.

e) Abuse can flow both to and from the elder to family or non-family caregivers.

f) Elder abuse crosses all ethnic, social and socioeconomic lines.

g) Some forms of elder abuse may be criminal wrong-doing.

4. WHO ARE THE VICTIMS OR POTENTIAL VICTIMS OF ELDER ABUSE?

(See Overhead III e, p. 159)
Earliest research pointed to the frail elderly who are:

a) very old
b) usually female
c) physically and/or cognitively impaired
d) dependent on others to perform basic tasks necessary for daily living
e) usually poor

More recent research shows that some elderly people who are not frail also experience abuse. This is particularly the case if family violence had been a pattern before the person became elderly. Some elder abuse has been found to be "spouse abuse grown old".

Characteristics of the caregiver such as substance abuse are now suspected to be more important predictors of elder abuse than characteristics of the elderly victim or potential victim.

5. WHO ARE THE PERPETRATORS OR POTENTIAL PERPETRATORS OF ELDER ABUSE?

(See Overhead III f, p. 161)

Abuse of the elderly relatives has been committed by spouses, adult children (both daughters and sons), siblings, and other distant relatives. More recent research implicates spouses most probably because more spouses than adult children live with the elder. The personal problems of the abuser are now receiving more attention as possible indicators of abuse, particularly substance abuse.

Other factors believed to contribute to potential abuse include: isolation, both geographic and social, lack of knowledge about aging and the elder's health and needs, lack of preparation for caregiving skills and aids, and lack of support, either because it is unavailable or unacceptable.

The highest risk situations are those in which there is alcohol or other substance abuse, a history of family violence, or the caregiver is expressing frustration, threatening punishment, or those whose resources cannot meet the needs of the elder.

6. WHY DOES ELDER ABUSE OCCUR?

(See Overhead III g, p. 163)

1. We are just beginning to learn this because the study of elder abuse is relatively new - important to study why elder abuse occurs so it can be prevented, and ways developed to help

2. Three general theories or frameworks regarding causes of elder abuse

Framework #1 - Environmental: emphasizes the dependency of the elder and stressors experienced by the caregiver.

Framework #2 - Pathological: views "problem" characteristics of the abuser as the main cause of abuse.

Framework #3 - Developmental Family Violence: views the use of force and violence within families as learned behavior. Therefore, an abused child learns to react with violence as an adult and passes this on to those under her/his care.

THEORY #1 ENVIRONMENTAL FRAMEWORK: CAREGIVER STRESS

Stress is a key factor is some situations in which the elderly are abused by their caregivers:

- physical and mental health problems
- low self-esteem, depression, anxiety

1) Who are caregivers?

- families:
  - spouses
  - adult children
  - siblings, siblings' children
  - cousins
  - friends and neighbors
- staff of institutions or private care homes

2) Work of the Caregivers:

- usually begins with one or two specific tasks
- amount and type of help increases over time
- may include intensive supervision if elderly person has dementia

3) **Why is caregiving so stressful?**
(See Overhead III i, p. 167)

- emotional demands--tied down, lack privacy
- urinary and bowel incontinence, night disturbance and aggressive behavior are most stressful
- dementia is the most stressful situation for caregivers; caregivers feel helpless, frustrated, and angry
- difficult family relationships (e.g.: rivalries, jealousies, ingratitude, favoritism)
- lack of support from other family members or community support services (e.g.: unavailable, unacceptable)
- isolation of the elderly person
- elder care is only one of several family concerns or problems (e.g.: unemployment, financial problems, problems with other family members, illness, substance abuse).

Note to Facilitator
Film vignette Elsie and Dorothy - This framework is dramatized in the video, "A House Divided" (See Appendix III, p. 117 & 121 for directions).

THEORY #2: PATHOLOGICAL FRAMEWORK - THE PATHOLOGY OF THE CAREGIVER

(See Overhead III g, p. 163)

1. "Problem" relatives are major risk factors in elder abuse, such as adult children who may:
   - be substance abusers (especially alcohol)
   - have a mentally disabling illness
   - be disabled by accident or illness
   - be experiencing social problems such as unemployment, inadequate income, or have poor-relationship skills

Note to Facilitator
You may choose to introduce the third vignette of the film: "A House Divided", the story of Margo (See Appendix III, p. 119 & 123 for suggestions). This vignette teaches about physical abuse resulting from a son's alcoholism. Margo, 73, is in poor health and lives near the poverty line. Her faith in her son persists despite the fact that he beats his mother when he is drunk.

## *THEORY #3*: THE DEVELOPMENTAL FRAMEWORK - FAMILY VIOLENCE

(See Overhead III g, p. 163)

1. Views abusive behavior as learned behavior (e.g.: person who grows up in a family where violence or abuse are patterns may, in turn, be abusive).

2. Other important factors:

a) not all families in which elder abuse occurs, have a history of family violence
b) not all abused elders were abusive parents
c) not all adults who were abused as children abuse their own children, parents, or other elders entrusted to their care.

3. This theory points to the need to help families learn better communication skills including frustration and anger management.

Note to Facilitator
You may choose to show the video vignette on Margo here. (See Appendix III, p. 119 & 123).

7. WHAT ARE THE BARRIERS TO IDENTIFYING ELDER ABUSE?

a) Why Don't the Abused and Abusers Report It?

(See Handout III a, p. 145, and Overhead III j, p. 169)

1) **Victims of abuse and the perpetrators of abuse rarely tell us. Why?**

* feelings of shame,
embarrassment,
disloyalty

* beliefs that they "get what they deserve",
that their relative would not "do that" if they had behaved "better",
that their problems are unsolvable

- fears of reprisals
  family break-up
  consequences such as a move to a nursing home
  exposure of an abused spouse or parent

- low self-esteem and lack of assertiveness

- cognitive impairment and resulting lack of recognition of abuse, inability to tell others and skepticism on the part of those told about the accuracy of their account.

b) Why Haven't We Seen Elder Abuse?
(See Handout III a, p. 145, and Overhead III k, p. 171)

1) **If elderly people have been abused over the years, why haven't we seen it?**

- we assume that since the elder does not tell us that it either does not happen or the elder consents to it

- we find it painful.
  - facing elder abuse brings us face-to-face with our cherished beliefs about families as loving and nurturing.
  - it is difficult for us to see that intense feelings of love go hand-in-hand with intense feelings of frustration and anger.
  - it is difficult for us to accept that "violence is an everyday occurrence" in families, and that the use of force in certain circumstances and by certain individuals within the family has been sanctioned by societal beliefs.
  - we need to recognize the signs, to become aware of the potential for abuse, and to develop a level of comfort in discussing abuse.

8. WHAT CAN BE DONE ABOUT ELDER ABUSE WHEN WE DO SEE IT?
(See Handout III b, p. 147)

1. Saskatchewan has no mandatory reporting of suspected cases of elder abuse.

2. No mandatory access to the alleged victim.

3. Access depends on the willingness of the alleged victim and perhaps, of the alleged perpetrator.

4. Visits help breakdown isolation (e.g.: family members, friends, neighbors clergy, health, and social service personnel).

5. Maintain non-judgmental attitude.

6. Only abuse that is a criminal offence will be investigated by police.

7. Focus on support needs of the total situation such as:
   - health services
   - geriatric hospitals
   - day hospitals
   - day centers
   - community outreach therapy
   - home care
   - community support groups
   - respite care
   - community workshops

8. Removal of alleged victim to another location is a last resort.

9. **STRATEGIES FOR INTERVENTION - A LOOK AT COMMUNITY RESOURCES**
   (See Handout III b, p. 147)

Elder Abuse is a complex issue with no easy answers or quick solutions.

Both the abused and abusers require assistance.

Some strategies which have been suggested for helping those affected by elder abuse include:

1. **Information and Training**

   - increase community awareness.
   - education programs to teach caregivers.
   - seniors need easy access to information.

2. **Environmental Supports**

- foster independence and autonomy of seniors.
- improve income security, housing, transportation, health and social care programs.

3. **Support Services for Abused/Abusers**

- intervention based on a restorative rather than punitive model.
- accessible counselling programs.
- accessible education programs (anger and stress management, life skills training).
- respite/day care for stressed caregivers.

4. **Legislative Change**

- changes in family law to facilitate ease of reporting and investigation.
- revise legislation on Power of Attorney, mental competency, guardianship, family violence.

5. **More knowledge**

- need to test the theories on what causes elder abuse.
- study multi-generational family systems more thoroughly.
- become informed of the experience of members of aboriginal and new immigrant communities.
- study needs to provide a community development approach to the issue rather than a purely academic inquiry.
- work toward enhancing community awareness and commitment to do something to eliminate elder abuse.

APPENDIX III

GROUP ACTIVITIES FOR WORKSHOP USE

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APPENDIX III

GROUP ACTIVITIES FOR WORKSHOP USE

A. VIDEO PRESENTATION "A HOUSE DIVIDED"

(produced by the National Film Board 1988)

We suggest workshop leaders obtain a copy of the video " A House Divided". This video is produced by the National Film Board and may be rented for a nominal fee. There is an excellent Study Guide published by National Film Board to accompany the video which helps to facilitate group discussion of each vignette. The vignettes are particularly helpful in discussing family relationships and identifying the causes/circumstances of abusive situations.

#1 - Elsie and Dorothy:
In the first vignette, Elsie and Dorothy provide an excellent dramatization of the stressed caregiver, the interplay between multi-generational family members, and other concepts familiar to the "Sandwich Generation". Selected questions from the National Film Board Study Guide, to use as handouts or guidelines in small group discussion, are attached.

#2 - The Muellers:
The vignette which tells the story of the Muellers is a sad example of fractured family relationships, (possibly due to caregiver stress, environmental factors such as unemployment, inadequate financial resources and competing needs among the generations of the family). The vignette highlights the concern of material abuse and indicates the community resources that were utilized by this elderly couple. Questions from the National Film Board Study Guide can help small groups to explore these issues further.

#3 - Margo:
The vignette featuring Margo portrays family relationships in which alcohol, across the generations violence and long standing interpersonal conflict can contribute to abusive situations. This particular vignette may be disturbing to some groups due to the frank depiction of Margo's injuries at the hands of her son. Care and attention to the effect the video might have on some groups is warranted. Again, questions from the National Film Board Study Guide which may be used to facilitate small group discussion of the issues raised in this vignette are attached.

#4 - Chinese Immigrants:
The fourth vignette relates the story of a recent immigrant to the USA from China. It would appear that this gentleman was the victim of material abuse by his adopted son, and has been effectively excluded from his family unit. The video gives an excellent description of a network of community resources engineered by the On Look Senior's program in San Francisco. Small groups may be interested in the dramatization of a group of professionals and volunteers working to identify and protect the elderly at risk.

Options for Using "A House Divided":

1. Workshop leaders could choose to show the video in it's entirety at one sitting or can intersperse particular vignettes throughout the day.

2. One or two vignettes could be used to focus on specific areas of concern, for example:

a) Elsie and Dorothy's story can be used to discuss caregiver stress, concerns arising from the decision to place a loved one, and intact healthy family relationships.
b) Margo's story could be used to highlight physical abuse and interpersonal problems.
c) Should groups want to focus on material abuse, the Mueller's story can illuminate key concepts.

Workshop leaders can decide where and how the video and study questions can contribute to their own format and presentation style.

TABLE GROUP QUESTIONS FOR USE WITH "A HOUSE DIVIDED"

VIGNETTE #1 - Elsie and Dorothy

A family discovers that their great love for their aging aunt is not enough to overcome the difficulties they encounter.

1. Elsie states in the vignette that, "You get feeling so desperate that you think, 'How am I going to go through another minute of this? What can I do to cope with it?"

   What can happen when a caregiver reaches this stage of hopelessness?

2. The literature indicates that the average length of time for caregiving in families is nine years. Elsie had been caring for Dorothy for eleven years.

   What are the needs and the rights of caregivers in such a situation?

3. Elsie says, "No one ever told me it was okay to hate-- even though you still love."

   How can we help caregivers to recognize that it is okay to feel hate, but it is also important to get help before these feelings are transferred into abusive action?

VIGNETTE #2 - Mr. and Mrs. Mueller

When adult children depend financially on their aging parents, the conflicts can tear the family apart. In this case, an initial period of harmony gives way to petty squabbles and finally to financial exploitation and fractured family relationships.

1. Why do you think older people who are being abused rarely report their treatment to the authorities?

2. Discuss this case as if it occurred in your own local community.

   - Who could Mrs. M. go to for help?
   - If your response to the above questions indicate that the community resources for situations like this one are insufficient, work in your group to design an integrated program that could respond to cases of suspect elder abuse in your home community. Be prepared to contribute your ideas for a community response program to the large group.

VIGNETTE #3 - Margo

Margo is 73, in poor health, and living near the poverty line. Her only surviving family member is a 33 year old son who beats her. Still, her faith in her son persists.

1. Margo blames herself for the way her son turned out--"I did not know anything about raising a boy."

   Do you believe she is to blame? Why or why not?

2. Why do you think Margo would tolerate being beaten time and again over a period of years?

3. Margo obviously loves her son very much. She wants him to have treatment so they can live together again. Does this seem to be a realistic goal?

4. What community agencies could offer assistance to people like Margo?

B. CASE STUDIES AND SUGGESTIONS FOR USE

Four case studies are included for discussion purposes. None describes an actual person or family. The case studies have been written to illustrate situations in which elder abuse can occur.

CASE STUDY #1 - THE J'S

The J's tells of the problem encountered by a mother and her mentally challenged son around whom her life has revolved. As both of them age, the mother requires assistance that her son has difficulty understanding and providing.

This case is useful in a discussion of neglect, abuse, causes of abuse, "problem" caregivers and identifying what resources are needed for support.

CASE STUDY #2 - MR. C.

Mr. C. describes an elderly man's confusion and need for care, the attempts of his daughter and family to provide this care and to involve him in family life. It explains the circumstances under which he changed his Will and the uncertainty and confusion he felt afterwards.

This case is useful in discussion of material abuse, causes of abuse, caregiver stress and the effects on family relationships.

CASE STUDY #3 - MRS. W.

Mrs. W. tells of an elderly woman taken into her daughter's home at a time of crisis. Her care needs increase over several years resulting in a lot of stress.

This case can be used to discuss causes of abuse including caregiver stress, stress and anger management, factors leading to physical abuse, and services that could be utilized to prevent abuse.

CASE STUDY #4 - MR. Y.

Mr. Y. describes the difficult adjustment of an elderly man to a nursing home, his relationships with staff, and a verbal exchange with a staff member.

This case is useful in a discussion of psychological abuse, factors that can lead to abuse in institutional settings, and steps that can be taken to alleviate problems.

SUGGESTIONS FOR USING CASE STUDIES:

1. Break out into small groups (3 to 5 groups) and discuss one case study per group.
2. Each group needs to choose a facilitator, recorder, reporter and a time keeper (people could double up on these roles).
3. Allow time for discussion.
4. When groups report back, they should briefly outline their case study for the group, then provide their response to the questions.
5. NOTE: You might have two groups doing each case study and then compare responses between groups.
6. Keep careful track of time during the reporting in. Encourage reporters to share the key points only in their responses.
7. The case studies should be photocopied so there are enough for each member of the small groups.
8. Questions for discussion are included in each case study.

The J's

Mrs. J. is an 84 year old widow who has looked after her son, John 58, since his birth. They live in a small, rundown home with few conveniences in Saskatoon. John works in a sheltered workshop and is able to go to and from by bus. At home, Mrs. J., as has been her practice since her marriage 61 years earlier, does all household tasks. Mrs. J's other three children live in Regina, Kelowna, and Prince George.

Over the past 4 - 5 years, John, who had always been the recipient of care, has increasingly had to look after his mother. Community workers are concerned. The homemaker who comes weekly, reports that both Mrs. J. and John yell at each other and she is afraid they will come to blows. John gives Mrs. J. his valium to "settle her" when he wants to go out in the evening.

He does not seem to understand that she no longer remembers to eat unless food is set out for her and frequently goes out without making sure that she has eaten.

One morning, John becomes angry when Mrs. J. scolds him. He pushed her away; she fell to the floor and broke her hip.

1. What do you think is the potential for abuse by both Mrs. J. and John?
2. What is the impact of the relationship between Mrs. J. and John on Mrs. J.'s need for care?
3. What suggestions do you have for help by community workers?

Mr. C.

Mr. C., 78, is diabetic, very forgetful and at times confused. His two adult children, son George and daughter Joan, became aware of his declining intellect when their mother died suddenly three years previously. Mr. C. was unable to manage his medications and his diet. He had increasing difficulty managing his household tasks and his bills, and was very lonely. He welcomed the opportunity to move in with his daughter, Joan, her husband, Tom and their three teenagers.

Joan and her family did their best to welcome Mr. C. into their home, as they had always been fond of him. Living arrangements are tight and two grandsons have to share a small room in order that Mr. C. have a room of his own. He is very critical of his grandsons' hair, dress, music and late hours on weekends. Joan spends most of her time with him because he refuses to see old friends or go to seniors' groups or a day center. The family involve him in all of their outings.

One day Mr. C. was taken by his son, George, (who rarely visits) to a lawyer's office where he changed his Will so that he benefitted more, Joan less. When Mr. C. returned, he told Joan what he had done and said he didn't want to do it, but did not know what to do.

1. What do you think is the potential for abuse in this situation?
2. In what ways might family relationships impact on Mr. C.'s care.
3. What suggestions do you have for Mr. C. and Joan regarding the changes made to Mr. C.'s Will?

Mrs. W.

Mrs. W. is an 85 year old widow who lived alone in her own home until she had cataract surgery, and hospital staff told her only daughter, Mary, that she was confused and not safe to live alone, and also that she was ready to be discharged from hospital that afternoon.

Mary and her husband, George, both 63, took her in to live with them. Mrs. W. did not understand why she could not go home. She made many attempts to go there, and on two occasions managed to get out of Mary's and George's home undetected. However, she became lost. Mary and George found she needed constant supervision and found her recriminations "hard to take." George increased the time he spent at work and with friends and though he was willing that Mary care for her mother in their home, he was not willing to help with her care. Mr. W's two adult sons who lived nearby did not visit or ask Mrs. W. to their homes.

Two and a half years later, we find the situation much the same. Mrs. W., however, has deteriorated, her speech is now a "word salad" and she talks mostly to herself. Mary has put on 15 pounds, she has difficulty sleeping , cries easily and is irritable. An old friend, a nurse who lives in another city, visits Mary who admits to her, "Sometimes I'm afraid of what I might do--I have caught myself ready to slap her."

1. What do you think is the potential for abuse in this situation?
2. In what ways might family relationships impact on Mrs. W's care needs?
3. If you were Mary's friend, how would you try to help?

Mr. Y.

Mr. Y. is an 80 year old man, physically disabled but mentally alert, who lives in a long-term care facility. He tends to minimize his disabilities and though has lived in the nursing home for two years, he still says that his 76 year old wife should look after him at home. He is very impatient and demanding of staff and has nothing positive to say about them or the facility.

One day he complained bitterly that as usual, he had waited half an hour to be put on the commode, and that he was fed up with waiting for staff who were more interested in their coffee breaks than in their work. He further said that he intended to take the matter to administration. The staff member told him that she had other people to look after too, and that it was time that he stopped acting like a child.

1. What is the potential for abuse here? What kinds of abuse are you concerned about?

2. Discuss alternative responses to Mr. Y. In what ways could more positive responses have an impact on Mr. Y's feelings about his situation and his attitudes to staff?

3. What are some appropriate ways of relating between residents of long-term care facilities, their families and their caregivers?

C. GENERAL GROUP DISCUSSION QUESTIONS

These could be used by the trainers to start a more general group discussion on the topic in various sections of a workshop. Pick and choose the ones that are appropriate for your situation:

1. Given that most elderly are competent and able to make their own decisions, do we have the right to infringe on their rights to freedom and independence through mandatory reporting legislation and adult protection laws?
2. How can we reduce the consequences of reporting for elder abuse victims? Can we ensure that mandatory reporting will not lead to inappropriate institutionalization of elder abuse victims?
3. Will mandatory reporting legislation convey the false hope that the needed follow-up support is available?
4. Should elder abuse be treated as a distinct category of abuse by crime prevention agencies?
5. How can we increase contacts outside the home for the elderly most at risk and increase their visibility to service providers?
6. How can we convince elderly victims they are not the major cause of their abuse and do not "deserve" it?
7. What is included in the definition of elder abuse? Does it just include physical, psychological, and financial harm done intentionally to an older person? Does it include neglect?
8. What constitutes physical abuse - beating? pushing? rough handling? what else?
9. What is included in the definition of psychological abuse - threats? making derogatory remarks? treating elderly person as a child? what else?

10. What about financial abuse? Do we adhere to the legal parameters of theft and fraud or take the definition further? What about theft of residents' personal property in nursing homes? Is that abuse?

11. What are the signs of the various types of physical abuse suffered by the elderly?

12. What are the signs of psychological abuse, such as threats, infantilization (treating like a child), derogation ("put downs")?

13. How do we detect financial abuse of the elderly, whether by their children or by fraudulent strangers?

14. What are the signs of neglect? How do we tell if it is neglect, poverty, indifference or stubbornness that results in these symptoms?

15. Who should get together and develop the protocols or guidelines for reporting suspected and confirmed cases of elder abuse? How can the effectiveness of the protocols be evaluated?

APPENDIX IV

HANDOUTS AND OVERHEADS

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Handout I a

RAISING OUR AWARENESS: A QUIZ ON AGING AND ELDER ABUSE

1. Most older people are physically weak and in poor condition. T F
2. Senility is a normal part of body breakdown. T F
3. Senile dementia is irreversible. T F
4. After the age of 65, the ability to learn is greatly diminished. T F
5. At least 15% of the aged are living in long stay institutions in Canada. T F
6. Older people today have less contact with their families than older people in the past. T F
7. The aging process causes people to become more self-absorbed and uninterested in others. T F
8. The majority of older people have incomes below the poverty level. T F
9. Elder abuse is a new phenomenon created by our modern society. T F
10. Elder abuse always involves physical contact. T F
11. The majority of elderly people complain about or report the mistreatment they receive. T F
12. The person who abuses an elderly person is not usually a family member. T F
13. Stress in the life of the caretaker is rarely a factor for precipitating abuse of the elderly. T F

Adapted from:Novak, M., Aging in Canada. Nelson, Canada, 1988.

RECOGNITION AND IDENTIFICATION OF ELDER ABUSE

Why don't elderly victims of abuse report it?

- They fear more abuse, humiliation and loss of their family caregiver
- they worry about the consequences of reporting, for example, being moved to a nursing home
- they may be cognitively impaired and if so, do not recognize that they are victims
- they believe that the role of spouse or parent is to love and nurture their spouse or children, not report their problems
- they fear exposure as a "bad" family or "bad" parents
- they believe family honor is at stake
- they believe that they should be able to solve their own problems or that their problems are without solution
- family breakup is unacceptable to them
- abuse victims have low self-esteem and lack assertiveness
- "I deserve what I get" is a common belief of abuse victims

Why don't we see elder abuse?

- lack of reporting leads to assumption of implicit consent
- reasons for lack of reporting and lack of options for abuse victim are not understood
- the sanctity of the family is highly valued
- the family's right to privacy is also valued
- the lack of knowledge of abusive situations
- a tendency to judge abuse as bad and the abuser as bad and an inability to move to a non-judgmental stance
- practical problems:"What do I do with an abused elderly person?"

SOME PRINCIPLES OF INTERVENTION

1. There is no mandatory reporting of elder abuse in Saskatchewan.
2. The Interhospital Domestic Violence Committee in Saskatchewan has developed a protocol for elder abuse and neglect which is being used in health care facilities in the province. A copy of the Elder Concern form is available from Saskatchewan Health.
3. The right of an adult to self-determination is a key underlying principle. Access to the older adult is at his or her discretion. Any intervention depends on acceptance by the older adults.
4. A non-judgmental attitude on the part of health and social service personnel is essential to intervention.
5. There is no screening or assessment tool that can be used to determine whether or not abuse has occurred. Determination of abuse is a judgment call.
6. The goals of intervention are prevention, protection and rehabilitation.
7. The focus of intervention is not the alleged abuse but the total situation. Assistance is offered to both the alleged victim and the alleged perpetrator.
8. Interventions should be the least restrictive and intrusive forms of assistance. Removal of the elder from home is the last resort and only when the elder is at grave risk.

" ... it would be hard to find
a group or institution
in [North] American Society
in which violence
is more of an everyday
occurrence than it is
within the family"

Steinmetz and Streus
Violence in the Family, 1974

ELDER ABUSE - A DEFINITION

... an act, committed

or omitted, by

another person, that

results in harm to

or jeopardizes the

well-being or safety

of an elder person

DEFINITIONS

PHYSICAL ABUSE

*

VERBAL/EMOTIONAL ABUSE

*

MATERIAL ABUSE/VIOLATION OF RIGHTS

*

NEGLECT

Summary: National Survey on Abuse of the Elderly in Canada, Podnieks, 1989:**

4% report abuse of some form

2.5% report material abuse

1.4% report psychological abuse

.5% report physical abuse

** NOTE: Telephone survey of elderly in private dwellings

Overhead III d

Some elder abuse
is "spouse abuse
grown old."

* * * * * * * * *

Non-frail elders
are also at risk.

Overhead III e

WHO ARE THE ABUSED?

Although any person may be abused, the majority of the abused elderly are:

* females over the age of 75;
* frail with physical and/or mental disabilities;
* often unable to provide for their own needs including their own protection;
* living with their abusers; and
* frequently reluctant or unwilling to report that abuse has actually occurred.

Source: Abuse and Neglect of the Elderly,
Health and Welfare Canada, 1986

Overhead III f

WHO ARE THE ABUSERS?

* A FAMILY MEMBER

- who is often also elderly
- often lives with and provides care for the victim
- is ill-prepared to provide care
- is isolated
- lacks personal and community support
- is subject to other stressors (e.g.: substance abuse which is a high risk factor, and/or health, social, or financial problems)

* NON-FAMILY CAREGIVERS

- in institutional or residential settings

Overhead III g

CAUSAL FACTORS

There are three basic theories of abuse:

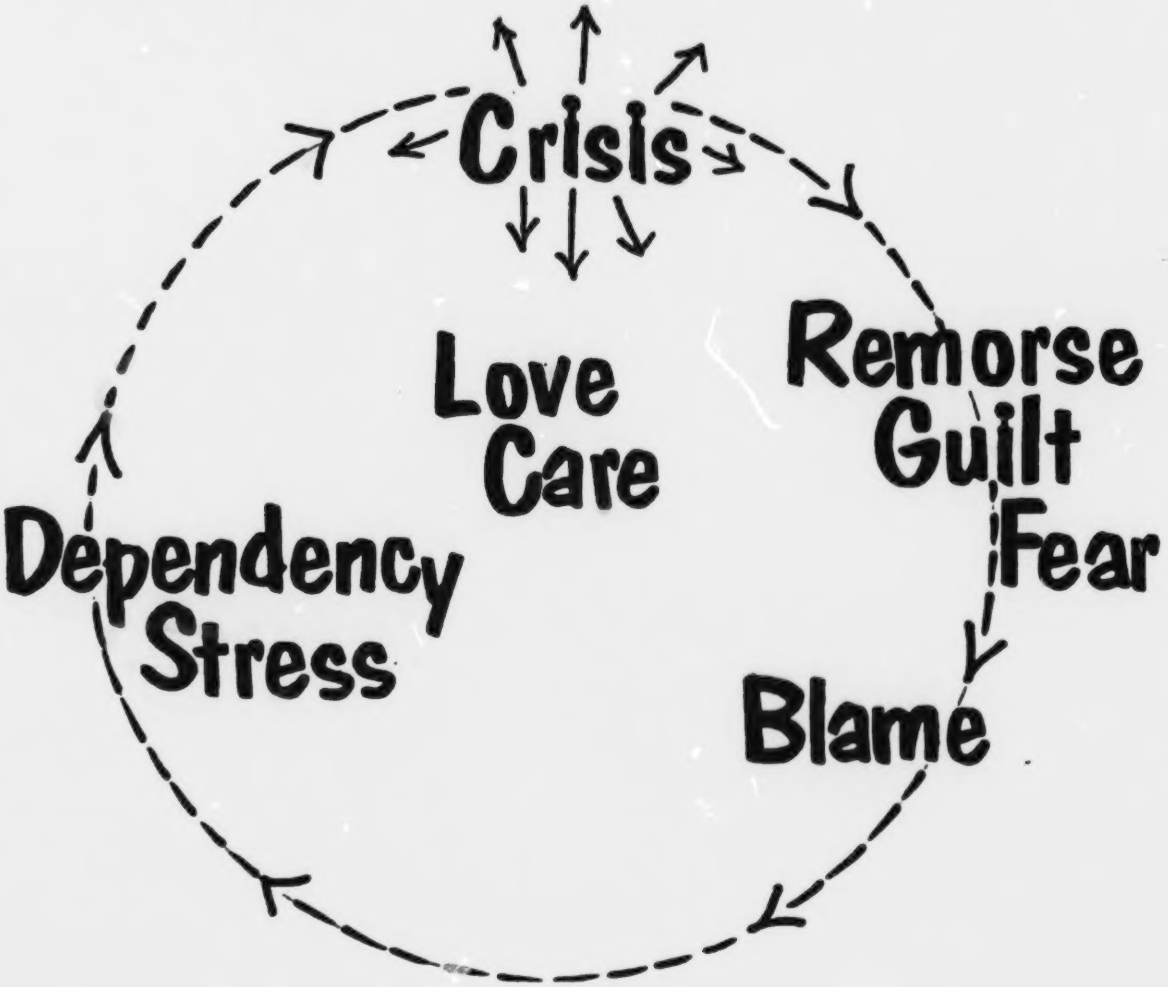
* The *Environmental Framework*: views present situations and social conditions as being the main causes of abusive behavior.

* The *Pathological Framework:* views abusive behavior as being determined solely by the personal or pathological problems of the abuse. Alcoholism, drug abuse, schizophrenia, and sociopathic behavior all fall under this category as possible explanations for elder abuse.

* The *Development Framework*: views domestic violence as a learned behavior which is passed on from generation to generation through established behavior patterns.

Source: Abuse and Neglect of the Elder,
Health and Welfare Canada, 1986

CYCLE OF VIOLENCE


Crisis
Love
Care
Remorse
Guilt
Fear
Blame
Dependency
Stress

Overhead III i

"One who has not

cared for an ill, helpless,

confused old person,

may not comprehend

the helplessness, rage

and frustration involved."

Dr. Muriel Lezak
Journal of Clinical Psychiatry
(39:592, 1978)

Overhead III j

WHY DON'T THE ABUSED ELDERLY REPORT IT?

1. Fear of more abuse, loss of caregiver.
2. Anxiety about consequences of reporting.
3. Impaired understanding.
4. Parental roles.
5. Fear of exposure.
6. Family honor.
7. Independence.
8. Family breakup is unacceptable.
9. Lack of self-esteem and assertiveness.
10. Believe "I deserve what I get".

WHY DON'T WE SEE ELDER ABUSE?

1. Lack of reporting.
2. Lack of awareness about elder abuse.
3. Society believes in the sanctity of the family.
4. Society believes in the family's right to privacy.
5. Use of force in certain circumstances is seen as OK.
6. Lack of knowledge about abusive situations.
7. Ageism.
8. Lack of options for dealing with an abused, elderly person.
9. Abuser thought to be a bad/sick person.

Overhead III 1

ELDER ABUSE - HIGH RISK SITUATIONS

- alcohol or other substance abuse
- history of family violence
- caregiver is frustrated, threatens punishment, has in-adequate resources to meet elders' needs
- social isolation

APPENDIX V

WORKSHOP EVALUATION

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Fax: *(306) 779-4825*

Prepared by:
People Focus
Saskatoon, Saskatchewan

APPENDIX V

WORKSHOP EVALUATION

As workshop leader or coordinator we encourage you to use the participant evaluation form to get direct feedback.

This feedback could be used to help make decisions about planning of future workshops--both their content and process. It will give you, the workshop leader, a picture of how this workshop was received and appreciated.

PARTICIPANT EVALUATION

ELDER ABUSE AWARENESS WORKSHOP

Please take ten minutes to respond to these questions. Use the back of this sheet for extra comments. Thank you.

A. What is your overall rating of the workshop? (check one).

Very Good ☐ Good ☐ Fair ☐ Poor ☐

B. To what extent do you think the workshop met the objectives (circle the appropriate number):

* to raise awareness of elder abuse issues and resources.

5	4	3	2	1
to a great extent				not at all

* to raise awareness of the need for community support systems for the elderly and their caregivers.

5	4	3	2	1
to a great extent				not at all

C. Usefulness of the resource materials (e.g.: reading material, handouts, overheads) (circle the appropriate number):

5	4	3	2	1
to a great extent				not at all useful

D. The degree to which the workshop leader provided clear, useful information and encourage group participation (circle the appropriate number):

5	4	3	2	1
to a great degree				not at all

E. The most useful piece of information I gained from this workshop is:

____

____

____

F. What suggestions do you have for improving this workshop?

____

____

____

G. One thing I will do to promote elder abuse awareness in my community is:

____

____

____

H. Other comments:

____

____

____

Appendix VI
Reading Resources

APPENDIX VI

READING RESOURCES

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Prepared by:
Elliot Paus Jenssen, Royal University Hospital and Pat MacKenzie, Faculty of Social Work, University of Regina, Saskatoon, Saskatchewan

APPENDIX VI

READING RESOURCES

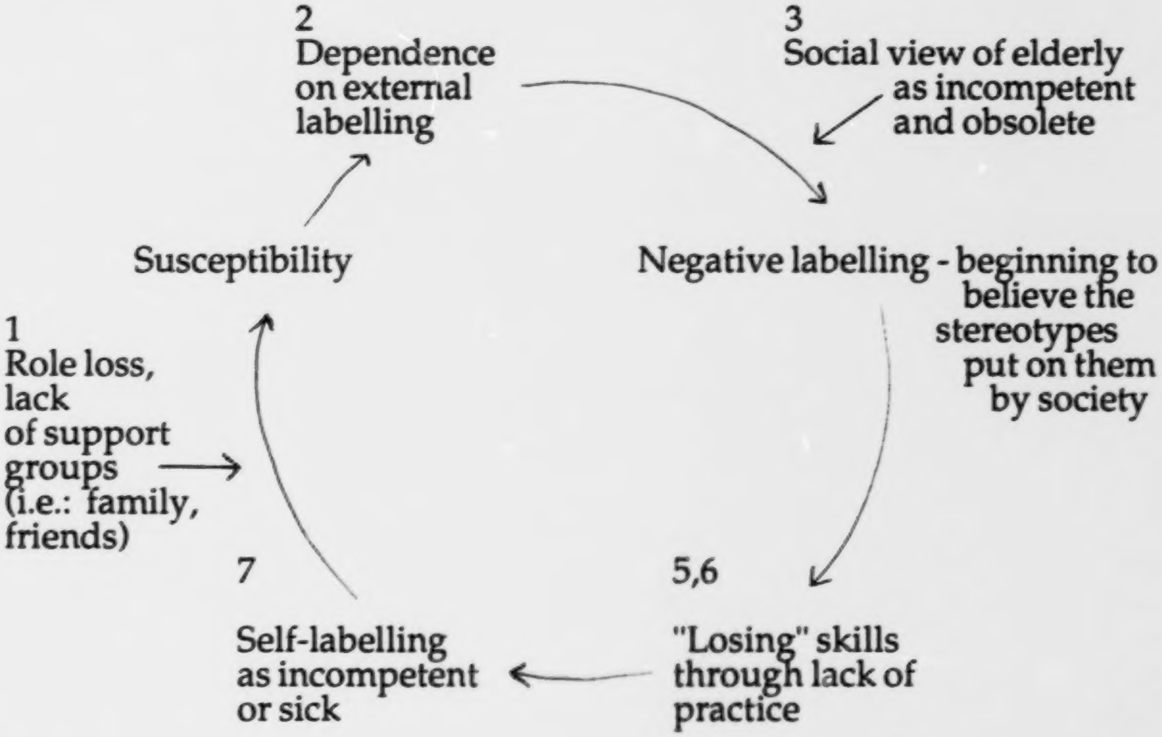
Framing The Problem Of Elder Abuse: The Social Environment

The work of two sociologists, J. Kuypers and V. Bengston (1973) helps to find a plausible explanation of the effect societal ageism has as a contributing cause to elder abuse in our society.

The Social Breakdown Syndrome poses a model which allows us to realize that older people may become susceptible to a host of social ills as a result of accepting the societal view that to "be old" is to be without value. They describe this syndrome as a seven-step process:

1. The passage of time brings role loss, the loss of friends and relatives to use a reference groups and support, and the perception by some that the old are "without social utility".
2. Some older persons may become dependent on external labels for a sense of self worth. In contemporary society, labels sometimes have negative connotations.
3. Social systems may view the older, dependent person as incompetent. Family and friends may begin to assume responsibility for an older person and in doing so inadvertently take away the older persons autonomy.
4. The older person may assume a dependent role in response to this treatment.
5. The older person learns to "live down" to expectations that people have of them.
6. The person loses (or relinquishes) previous skills in the activities of daily living because they do not have the opportunity to maintain competence.

SOCIAL BREAKDOWN SYNDROME



2
Dependence on external labelling
3
Social view of elderly as incompetent and obsolete
Susceptibility
Negative labelling - beginning to believe the stereotypes put on them by society
1
Role loss, lack of support groups (i.e.: family, friends)
7
5,6
Self-labelling as incompetent or sick
"Losing" skills through lack of practice

Adapted from:

Source: **J.A. Kuypers and V.L. Bengston, "Social Breakdown and Competence: A Model of Normal Aging",** ***Human Development 16*** **(1973): 181-201.**

To find an answer to another important question - "What can be done to change the system and prevent mistreatment from occurring?", Kuypers and Bengston (1973) suggest that these societal attitudes and conditions can be reversed. The Social Reconstruction Syndrome proposes a reorganization of the social system to provide older people with new opportunities to feel worthwhile:

1. The creation of a societal value system that bases social worth on a person's basic humanity, not on what he or she produces. For those concerned with senior's, significant work must be done to liberate society from a purely functional work ethic which gives value only to those whose function is to contribute to the creation of the Gross National Product. As a society we must revere, not fear, the later phase of life.

2. Fostering in every person a sense of independence and self-reliance, no matter how fragile the individual.

3. Encouraging the development of a strong internal sense of evaluation and control. All persons live in social environments and therefore we obtain our sense of self from others. We must become better able to give each other and ourselves "I have value" messages.

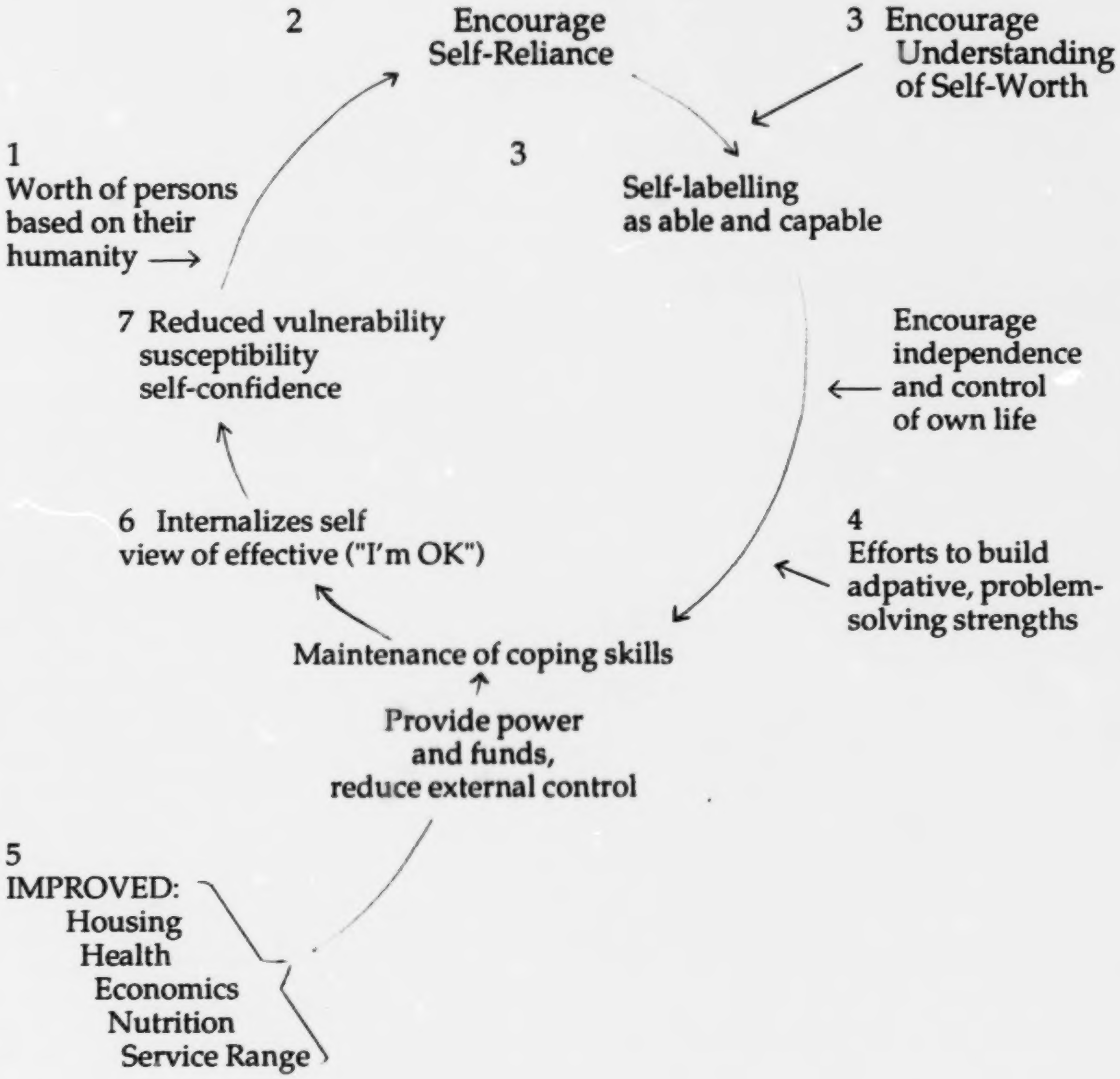
4. In social relationships (particularly in the informal and formal caregiving systems) work to create a climate which fosters learning new problem solving techniques throughout the life cycle.

5. Advocate and develop better quality services such as income security, housing options, social opportunities, and a broad based health care system (which enhances the informal caregivers by providing adult day care, respite care, home supports, long term care and first rate geriatric medicine etc.)

6. The provision of services indicated in point #5, coupled with the encouragement of positive self evaluation, the elimination of ageist attitudes in society, and the acquisition of creative problem solving strategies throughout the life cycle will allow all aging persons to maintain their coping skills and adapt to the challenges of aging.

7. The reconstruction of social relationships in a supportive and non-ageist society will create a society which is less tolerant of abuse to vulnerable groups and reduced susceptibility of the aged to external forces. A reduced tolerance of abuse when it occurs will lead to more frequent reporting and greater opportunities for investigation and intervention.

A POSSIBLE SOCIAL RECONSTRUCTION SYNDROME


2
Encourage Self-Reliance
3 Encourage Understanding of Self-Worth
1
Worth of persons based on their humanity
3
Self-labelling as able and capable
7 Reduced vulnerability susceptibility self-confidence
Encourage independence and control of own life
6 Internalizes self view of effective ("I'm OK")
4
Efforts to build adpative, problem-solving strengths
Maintenance of coping skills
Provide power and funds, reduce external control
5
IMPROVED:
Housing
Health
Economics
Nutrition
Service Range

Adapted from:

Source:
J.A. Kuypers and V.L. Bengston, "Social Breakdown and Competence: A Model of Normal Aging, "*Human Development 16* (1973), 181-201.

It should be noted that the "Social Reconstruction Syndrome" proposes changes in how older people are viewed and supported in society. An improvement on any of these items would increase the older person's quality of life.

The responsibility of making these changes is one all members of society share. The best strategy for dealing with elder abuse is to prevent it by supporting the autonomy and quality of life for seniors, both in the community and in institutions.

In this context, there are attitudinal issues to be grappled with. Should we find our collective will to make changes lacking, it is sobering to realize that we must make these changes for at least one good reason: as the aged of tomorrow, it is in our own self-interest! As well, making such change will also go a long way towards eliminating one of the major factors contributing to a sad social commentary - abuse of the most vulnerable groups in our society.

AlzheimeRapport
Vol. 11 No. 3, Fall 1988

Potential for abuse of Alzheimer victims is great

It's 6:30 a.m. on a working day in April of last year. I'm trying to get my wife to come down to breakfast before I have to go to work. She is screaming, her arms are flailing and she's trying to hit me. In desperation, I slap her face. My rationale is that it is the only way to stop a hysterical outburst.

I've been haunted ever since by the thought that I was venting frustration and resentment that had been building for years. If that were true, then what I had done was unforgivable. Guilty or not, the potential for abuse was and is there, not just for me, but for anyone in the same circumstances.

My feelings at the onset of my wife's illness were, in turn, disbelief, anger, fear, and sorrow - all powerful emotions. They were not just for the moment - a passing thing - they stayed with me. I think they are with me still - smoldering just below the surface.

Over the past five years, I have felt guilt, resentment, anxiety, frustration, and worry. That's a formidable list of negative emotions. There has been little or nothing to counter-balance that list.

In spite of all the negative feelings, you have to cope. You have to go on living. How you do that? It's quite a challenge, and very stressful, but I think there are two basic rules that were of assistance to me. First, organization, second, living one day at a time.

To me, organization is the key. Without it, what is already a stressful situation can quickly become intolerable. And that can lead to abuse.

To minimize that potential, a routine should be established and adhered to. The unexpected is to be avoided as much as possible.

The second basic rule is to take things one day at a time. A certain amount of planning is essential, but for the most part everything should be done on a daily basis. It's a state of mind that you have to put yourself in - think only of the next 24 hours and what can be done and what can be left undone. If you don't adopt that attitude, then you can quickly become overwhelmed.

I think it's also important for the caregiver to understand the stress that Alzheimer Disease places on a relationship. As the disease progresses, you must know that eventually you will lose your mate, even though the person is still there in body. The caregiver must reconcile himself to that - and it's not easy.

As an active member of the workforce, I also understand the stress and strain that working and caring for an Alzheimer victim can cause.

In my case, it was a second career, and I'm doing something I enjoy, so I'm not concerned about advancing up the ladder of success. However, one or two opportunities have arisen and I've had to turn them down. It would have meant added responsibility, more time away and a greater reliance on other people to look after Lois.

It's a question of coming to terms with the situation. In my case it was not difficult, but the potential for resentment is there.

All I've said so far deals with potential for physical abuse. There is another kind of abuse. I call it mental abuse - and it may not be deliberate. I refer to the times when a caregiver speaks sharply or impatiently to an Alzheimer victim, as I have on a number of occasions. It happens after endless repetition. It happens at the end of a long day when you are trying desperately to get your spouse to do a simple task. It happens when you have made extra effort on a special occasion only to be net with indifference or open hostility.

I've tried to give you a picture of what my life has been like for the past five years in the hope that it will prove useful.

The potential for abuse is great. I do know that you have to work hard at being the loving, patient, kind and tolerant caregiver that every Alzheimer victim needs. I also know that however hard you think you're trying - you don't always succeed.

By Reg Redknap
Ottawa

APPENDIX VII

GLOSSARY OF TERMS

Appendix VII
Glossary

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APPENDIX VII

GLOSSARY OF TERMS

- **Abuse** - mistreatment, behavior that results in injury or harm.
- **Caregiver** - one who gives care to another.
- **Dementia** - loss of intellectual abilities severe enough to interfere with social or occupational functioning.
- **Development Stressor** - a source of stress resulting from personal or environmental change.
- **Financial Abuse** - misuse or theft of finances.
- **Institutional Abuse** - abusive behavior by staff of an institution toward residents.
- **Mandatory Access** - right to approach abused person and/or abusive situation required by legislation.
- **Mandatory Reporting** - reporting required by legislation to a specified authority.
- **Material Abuse** - theft or misuse of money, property or possessions.
- **Neglect** - failure by an authorized caregiver to meet the needs of an elder who is unable to meet his/her own needs.
- **Perpetrator of Abuse** - one who commits abuse; an abuser.
- **Physical Abuse** - infliction of physical discomfort, pain or injury.
- **Psychological Abuse** - emotional abuse, chronic verbal abuse, infliction of mental anguish.

- **Respite Care** - care that provides a break in caregiving for the usual caregiver; it may be provided in a nursing home for a week or two, in a day center, or in the elder's home by a Home Care attendant or a privately hired caregiver.

- **Transgenerational** - across three or more generations.

- **Verbal Abuse** - a form of psychological abuse.

- **Victimization** - criminal offences committed towards the elderly by people who are neither their family nor their caregivers.

APPENDIX VIII

BIBLIOGRAPHY, READINGS AND RESOURCES

Elder Abuse Prevention Project
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APPENDIX VIII

BIBLIOGRAPHY, READINGS AND RESOURCES

Readings and Resources

The Journal of Elder Abuse and Neglect has recently begun production. Subscriptions are available from the publisher, Haunt Press, # 12 West 32nd St. New York, N.Y. 1001-3813

The federal Seniors Secretariat, in collaboration with the Family Violence Prevention Division, Health and Welfare Canada, has compiled a document entitled A Shared Concern: An Overview of Canadian Programs Addressing the Abuse of Seniors, 1991. This document provides a descriptive overview of elder abuse programs, services and protocols available in each province.

Elder Abuse Bibliographies have been published by:

Seniors' Education Center(1991)
University Extension
University of Regina
Regina, Sask. S4S 0A2

National Clearing House on Family Violence(1991)
Family Violence Prevention Division
Social Services Programs Branch
Health and Welfare Canada
6th Floor, Brooke Claxton Bldg
Tunney's Pasture
Ottawa, Ont. K1A 0K9

Social Planning and Research Council of B.C.(1990)
106 - 2182 West 12th Ave.
Vancouver, B.C. V6K 2N4

Additional articles and texts which may be helpful (or have been cited in this Module) are listed below. This bibliography is by no means exhaustive. New material is being published every month on the issue of elder abuse.

Note: Most of these texts and articles are available at your local library through interlibrary loans. Allow several weeks for delivery.

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